U.S. Department of Health and Human Services

Health Care Financing Administration

Financial Report

Fiscal Year 1998

HCFA

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1998

U.S. Department of Health and Human Services
Donna E. Shalala, Secretary

Health Care Financing Administration
Nancy-Ann Min DeParle, Administrator

THE Chief Financial Officers (CFO) Act of 1990 (P.L. 101-576) marks a major effort to improve U.S. Government financial management and accountability. In pursuit of this goal, the Act instituted a new Federal financial management structure and process modeled on private sector practices. It also established in all major agencies the position of Chief Financial Officer with responsibilities including annual publication of financial statements and an accompanying report. The form and content of this Financial Report follow guidance provided by the Department of Health and Human Services, the Office of Management and Budget, and the General Accounting Office. It reflects the Health Care Financing Administration's (HCFA) support of the spirit and requirements of the CFO Act and our continuing commitment to improve agency financial reporting.

U.S. Department of Health and Human Services
Health Care Financing Administration
7500 Security Boulevard
Baltimore, Maryland 21244-1850

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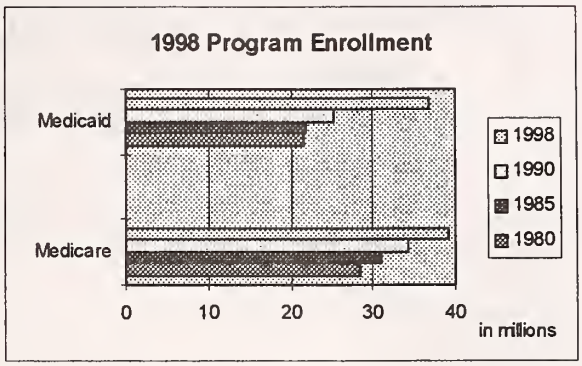
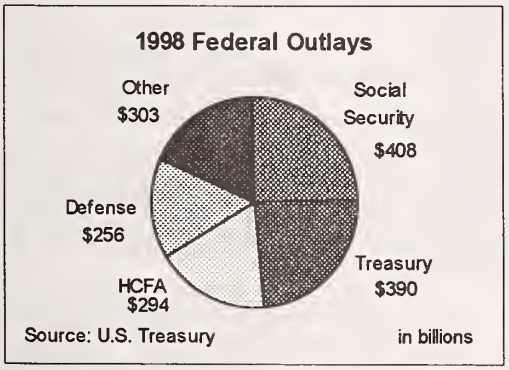
1998

The Health Care Financing Administration AT A GLANCE

➤HCFA celebrated the 32nd Anniversary of the Medicare and Medicaid programs in 1998. Over the past 32 years, Medicare enrollment increased from 19.5 million beneficiaries in 1967 to 39.2 million beneficiaries today. Recipients of Medicaid services increased from 10 million beneficiaries in 1967 to 35.4 million beneficiaries in 1998. We cover one in four Americans.





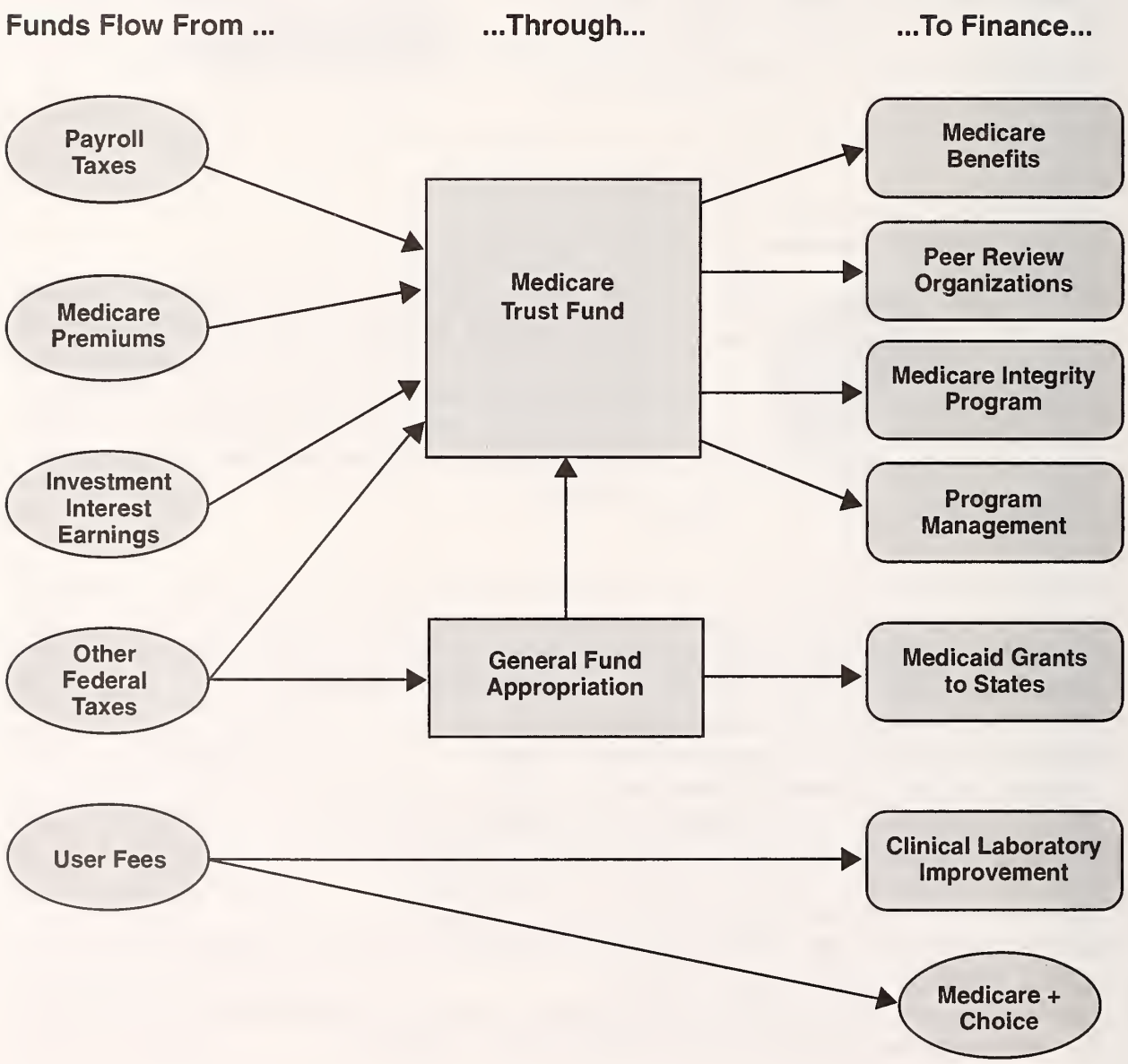
➤ HCFA and the programs it administers outlayed $294 billion in fiscal year (FY) 1998, 17.8 percent of the total Federal outlays. The only agencies that outlayed more are Social Security and the Department of Treasury, specifically the Interest on the Public Debt. HCFA is the largest purchaser of health care in the world.

➤HCFA has 3,950 Federal employees, but does most of its work through third parties. HCFA is responsible for funding Medicare and Medicaid and safeguarding their fiscal integrity. HCFA also assures the safety and quality of medical facilities, provides health insurance protections to workers changing jobs, and maintains the largest collection of health care data in the United States. HCFA and its contractors pay more than 860 million Medicare claims annually, monitor quality of care, provide States with matching funds for Medicaid benefits, and develop policies and procedures designed to give the best possible service to beneficiaries.

HCFA and Its Partners

Type	Employees
HCFA	3,950
Medicare Contractors	22,000
State Medicaid	34,000
State Surveyors	6,000
Peer Review	1,600

FINANCING OF HCFA PROGRAMS & OPERATIONS



A Message from the Administrator

I am pleased to provide HCFA's annual financial report for fiscal year (FY) 1998. For more than three decades, Medicare and Medicaid have met the health care needs of elderly, disabled, and low-income Americans. Today, over 70 million Americans rely on these programs. Our objective is to work with the Congress, the states, our beneficiaries, and our provider partners to ensure that Medicare and Medicaid are strong and well managed.

We have had a busy year in 1998. We implemented many very important provisions of the Balanced Budget Act of 1997: the Medicare+Choice program; the prospective payment system for skilled nursing facilities; the competitive bidding demonstration for durable medical equipment; and coverage changes related to bone-mass measurement, diabetes self-management, venipuncture, telemedicine, and others. We approved Children's Health Insurance Plans to cover a projected two million additional children for nearly half the states. We began a new initiative to provide enhanced protections for nursing home residents, and we continue to work closely with state insurance regulators in monitoring enforcement of important Health Insurance Portability and Accountability Act provisions.

A comprehensive plan for Program Integrity has been developed that focuses on areas that present a significant opportunity for progress in improving the overall fiscal integrity of our programs. We are pleased to note that the estimated claims error rate for 1998 has fallen to 7.1 percent compared to 11 percent for 1997. We are pleased that the numbers are moving in the right direction and we will continue to focus our corrective actions on those high risk areas that were identified in the audit as posing significant vulnerabilities.

We have also focused our resources on readying our computers for the millennium. One of our highest priorities must be to ensure that health care services for our beneficiaries are not affected by computer failures on January 1, 2000. Until we have assured ourselves of millennium success, we cannot undertake new system or contractor efforts that draw upon the same resources that we depend upon for millennium efforts. We will be watching this issue closely to minimize any short term delays that might occur as we implement the remainder of the Balanced Budget Act provisions.

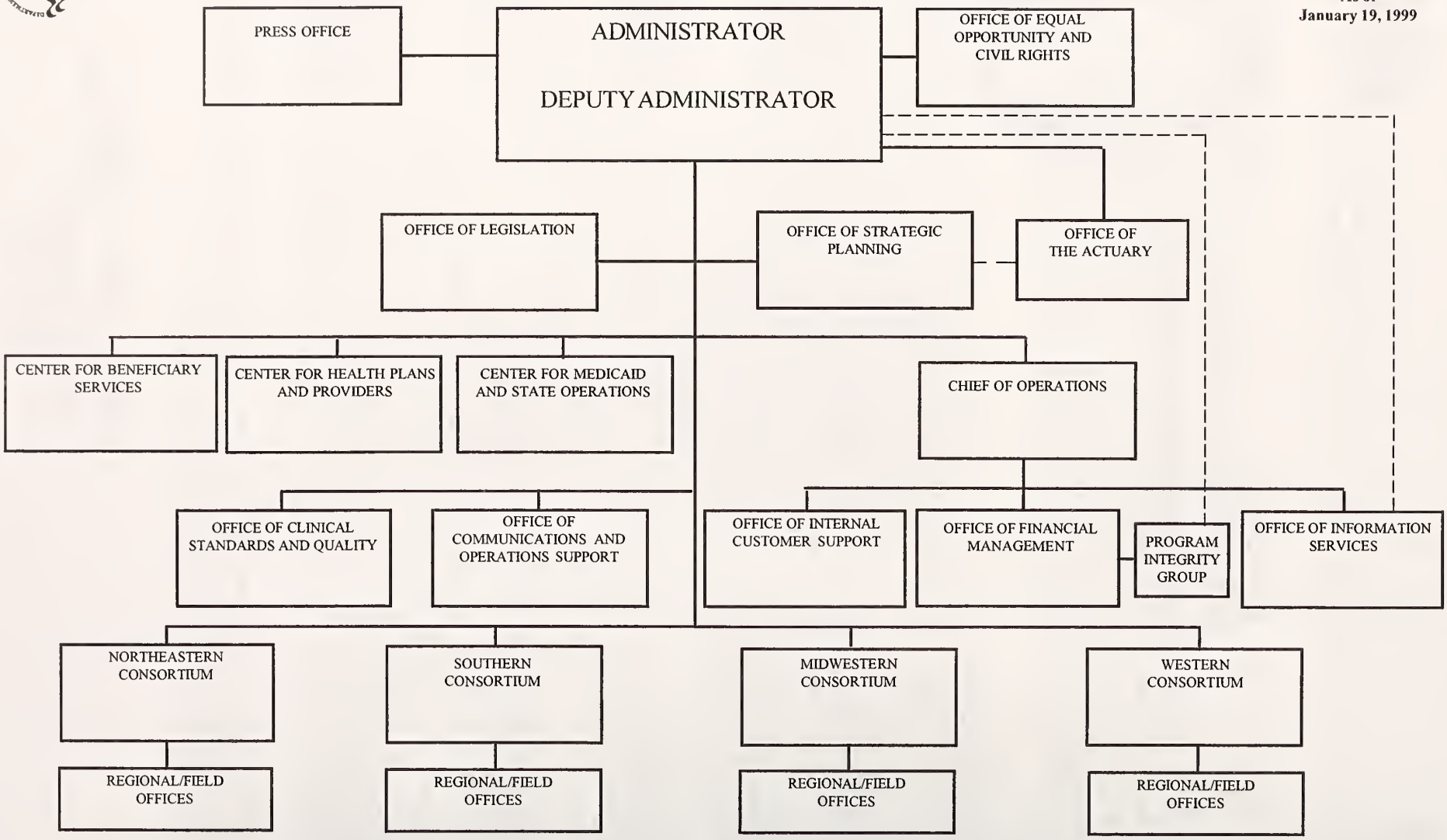
As we face the future and the work that lies ahead, I am proud of what HCFA is doing to meet these challenges. We have changed the way we do business to focus not on what works best for the agency, but what works best for the beneficiaries we serve.

Nancy-Ann Min DeParle
February 1999

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

APPROVED
LEADERSHIP

As of
January 19, 1999



A Message from the Chief Financial Officer

As HCFA's Chief Financial Officer (CFO), I am pleased to report that in FY 1998, we continued to make significant progress in improving financial management at HCFA. Prudent financial management is critical in this era of severely limited Federal resources. As an agency with one of the largest budgets in the Federal government, we in HCFA have a special obligation to ensure that we spend each dollar, whether for benefits or administration, as wisely as possible.

HCFA's financial management challenges are unique within the Federal Government. Medicare and Medicaid benefit payments are paid by 66 Medicare contractors and all of the states and territories, using multiple systems and processes, which compound the difficulty, complexity, and expense of making system and operating changes. These systems were designed to pay medical providers and suppliers and, although program audits find that the systems are doing the job for which they were intended, e.g., ensuring eligibility of beneficiaries and providers, pricing out medical procedures, and paying bills properly, the systems do not meet requirements for an integrated accounting system.

The 1998 audit indicates that our auditors continue to have concerns over accounts receivable reported by the Medicare contractors. We share this concern. Until a fully integrated contractor-based accounting system is implemented at each contractor, we anticipate extra efforts will be necessary to support accounts receivable. Although we received a qualified opinion for FY 1998, we believe we made progress towards our goal of receiving an unqualified opinion. During FY 1998, we began developing two new systems, the Medicare Accounts Receivable System (MARS) and the Integrated MSP Recovery Management and Accounting System (ReMAS) that will improve oversight and financial reporting over Medicare receivables. In addition, we have worked closely with the Medicare contractors to improve their financial reporting by visiting contractors, holding a financial management conference, and developing new financial reporting procedures that will address many of the auditors' concerns.

We made important accomplishments as well in other financial areas. We continue to pay all of our administrative payments on time in compliance with the Prompt Payment Act. Over 90 percent of our payments are paid electronically. We implemented the Debt Collection Improvement Act and collected over $1.6 million of delinquent Medicare debts. We began implementation of an automated, user-friendly, electronic travel system that will eliminate the paperwork burden on travelers and administrative staff and will streamline the process for reimbursing travelers' expenses.

Much of our energy during FY 1998 was focused on making sure our internal financial systems meet Y2K compliance. HCFA's accounting system, the Financial Accounting Control System (FACS), has been renovated and undergone independent, internal Y2K validation and verification review. Internal certification was completed in 1998 with the code scheduled for implementation in early 1999. Besides renovating and testing our internal systems, we have taken a lead role in HCFA's Y2K contingency planning efforts to ensure that contingency plans address system failures that could affect payment systems and that feasible safeguards are in place to protect payments.

We also had significant accomplishments during FY 1998 in program integrity. HCFA took great strides reaching out to our partners at a National Fraud, Waste and Abuse Conference held in March 1998. This conference provided a forum for executive- level public and private sector representatives and HCFA partners to share their experiences and insights about fighting fraud, waste and abuse. Building in part on lessons learned at the conference, we developed a Comprehensive Plan for Program Integrity. The Plan lays out a strategy for addressing the challenges of safeguarding payments in today's complex health care marketplace.

Our increased focus on program integrity has paid off. Based on the Office of the Inspector General's (OIG) report entitled "Improper FY 1998 Medicare Fee-For-Service Payments,, (A-17-99-00099), the OIG indicated that Medicare's fee-for-service payment error rate for FY 1998 was 7.1 percent, or $12.6 billion. This error rate is $10.6 billion less than for FY 1996, when the OIG developed the first national error rate. This reduction was attributed to HCFA's efforts under the Medicare Integrity program, fraud and abuse initiatives, improved provider compliance with Medicare reimbursement rules, HCFA/OIG efforts to emphasize provider compliance with Medicare documentation requirements to support services billed, and implementation of HCFA's corrective action plan.

Although we are pleased with these results, we know we have much more to do. Implementation of our Comprehensive Plan should further decrease the error rate by focusing on improving medical review and benefit integrity, ensuring provider integrity, developing payment safeguards as new programs and payment methods are implemented, implementing contracting authority for the Medicare Integrity Plan, and developing program integrity contingency plans. In pursuing these important areas, we will be using our partnerships with providers and beneficiaries to strengthen and protect the program.

HCFA takes it financial management responsibilities very seriously. We are committed to reducing payment errors, identifying and eliminating health care fraud, improving program oversight, and implementing a state-of-the-art Medicare contractor accounting system. These are challenging tasks, but ones, nonetheless, that we will accomplish.

Michelle Snyder

Michelle Snyder
February 1999

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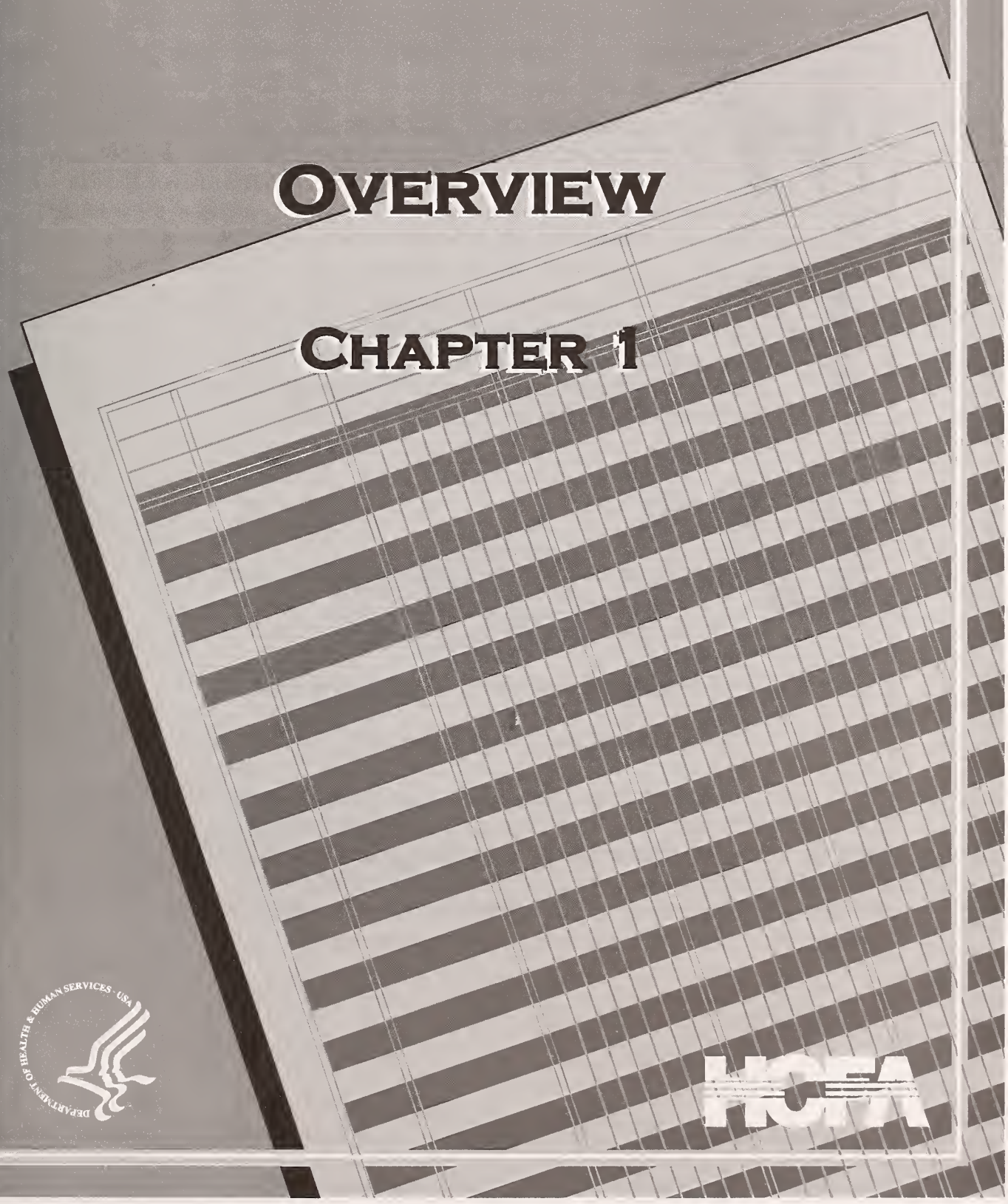
Overview

Chapter 1



OUR MISSION, VISION, AND GOALS

MISSION **We assure health care security for beneficiaries**. Health care security means access to affordable and quality health care services, protection of the rights and dignity of beneficiaries, and provision of clear and useful information to beneficiaries and providers to assist them in making health care decisions.

VISION **We guarantee equal access to the best health care**. This vision reflects our commitment that all individuals will be given an unconditional assurance of having the same opportunity to have their health care needs met, regardless of location, income, or other circumstances, and the quality of health care they receive is the best that can be provided.

GOALS

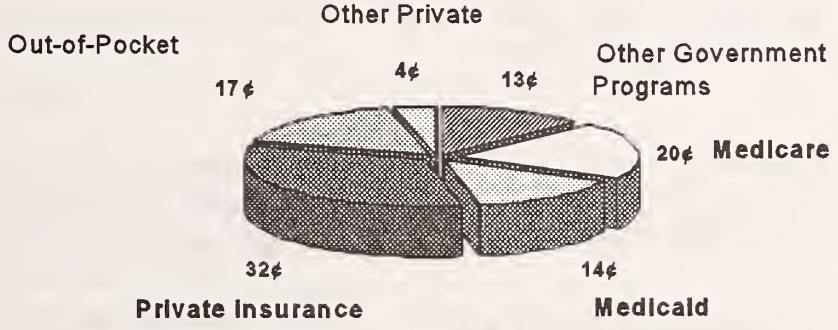
- Protect and improve beneficiary health and satisfaction
- Promote fiscal integrity of HCFA's programs
- Purchase the best value health care for beneficiaries
- Promote beneficiary and public understanding of HCFA and its programs
- Foster excellence in the design and administration of HCFA's programs
- Provide leadership in the broader public interest to improve health

Program Profile

The Health Care Financing Administration (HCFA), an operating division of the Department of Health and Human Services (HHS), is responsible for administering Medicare, Medicaid, the Clinical Laboratory Improvement Act, and, beginning in 1998, the State Children's Health Insurance Program. In connection with the Departments of Labor and Treasury, HCFA (on behalf of HHS) is also responsible for oversight of the insurance reform provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

HCFA is the largest purchaser of health care in the world. Medicare and Medicaid outlays, including State funding, represent 34.2 cents of every dollar spent on health care in the United States -- 59.9 cents of every dollar spent on nursing homes, 48.8 cents of every dollar received by U.S. hospitals, and 28.5 cents of every dollar spent on physician services.

The Nation's Health Care Dollar 1997



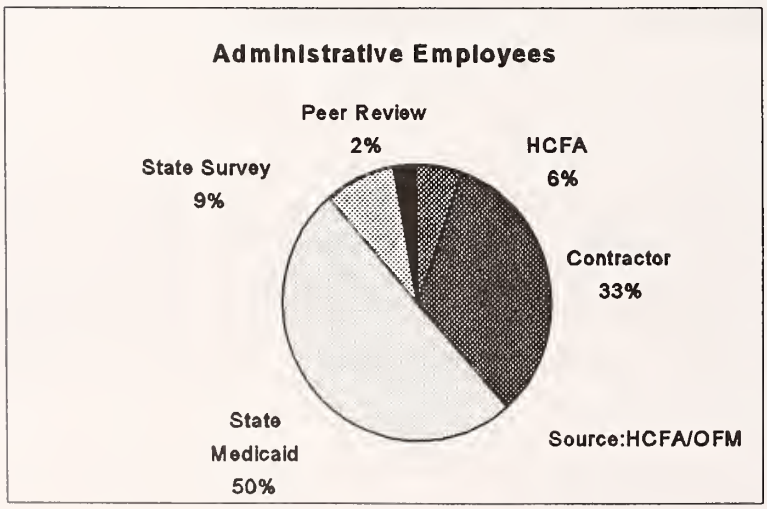
Source:HCFA/OACT

HCFA and the programs it administers outlayed $294 billion in fiscal year (FY) 1998, 17.8 percent of total Federal outlays. HCFA establishes rules for eligibility and benefit payments; funds over 860 million Medicare benefits claims annually; provides States with matching funds for Medicaid benefits; assures quality of health care for beneficiaries; safeguards funds from fraud, abuse, and waste; and carries out many other important activities.

Of HCFA's 3,950 Federal employees, about 1,450 work in 10 regional offices around the country providing direct services to Medicare contractors, State agencies, providers, beneficiaries, and the general public. Approximately 2,500 of HCFA's employees work in Baltimore and Washington, D.C., providing funds to Medicare contractors; writing policies and regulations; developing more efficient operating systems; setting payment rates; managing programs to fight fraud, waste, and abuse; monitoring contractor performance; developing and implementing customer service improvements; surveying hospitals, nursing homes, labs, home health agencies and other health care facilities; working with State insurance companies; and assisting States and Territories with Medicaid and other issues.

Two key financial terms are critical to understanding of the HCFA financial story. **Expenses** are one of the ingredients of the financial statements that begin on page 51. Expenses are computed using accrual accounting techniques which recognize costs when incurred and revenues when earned and include the effect of accounts receivable and accounts payable on determining annual income. Wherever possible, expenses are the basis for discussions of HCFA's financial activity. **Outlays** refer to the issuance of checks, disbursement of cash, or electronic transfer of funds made to liquidate an expense regardless of the fiscal year the service was provided or the expense was incurred. Outlays are used in the discussions of HCFA's financial activity only when comparable expense data are not available.

In 1998, HCFA's expenses total $312 billion. Administrative expenses of $2.9 billion are less than one percent of the total. In addition to HCFA's approximately 3,950 Federal employees, many important operational activities are handled through third parties: (1) 22,000 employees at 66 Medicare contractors have primary responsibility for processing Medicare claims, providing technical assistance to providers and servicing beneficiaries needs, including enrollment and premium billing, and responding to inquiries; (2) 34,000 State employees have primary responsibility for administering Medicaid; (3) 6,000 State employees have primary responsibility for inspecting



hospitals, nursing homes, and other facilities to ensure that health and safety standards are met; and (4) 1,600 employees at 53 Peer Review Organizations conduct a wide variety of quality improvement programs to ensure quality of care provided to Medicare beneficiaries. The Administrative expenses also include the services of the Social Security Administration (SSA), the Railroad Retirement Board (RRB), and other Federal agencies. These agencies provide thousands of other staff, in support of Medicare and/or Medicaid operations, developing, implementing, and measuring customer service and clinical health quality improvements; providing consumer information that assists beneficiaries with making choices in health care; and assisting States and Territories with Medicaid and other issues. HCFA carries out many important activities, including:

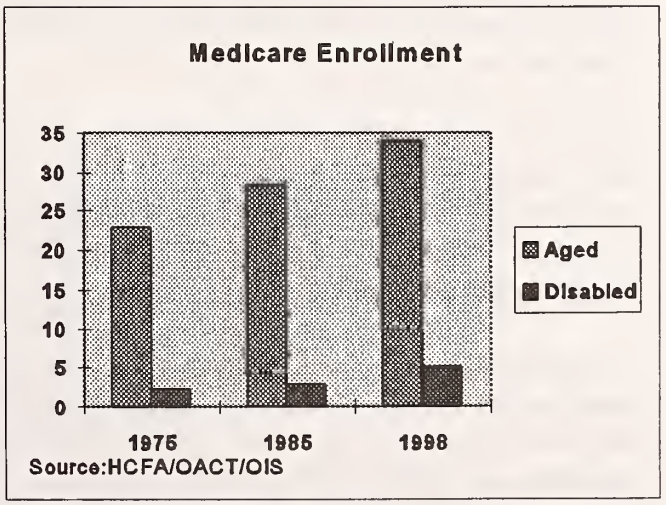
- safeguarding the fiscal integrity of the Medicare and Medicaid programs to ensure that benefit payments for appropriate, medically necessary services are paid correctly the first time; recovering improper payments; and assisting law enforcement agencies in the prosecution of fraudulent activities.

- maintaining the Nation's largest collection of health care data and providing data and analytical services to the Congress, the Executive Branch, universities, and other private sector researchers.

- assuring health care security for beneficiaries.

MEDICARE

Title XVIII of the Social Security Act was established by the Social Security Amendments of 1965. Legislated as a complement to Social Security retirement, survivors, and disability benefits, Medicare originally covered people aged 65 and over. In 1972, the program was broadened to cover the disabled, people with end-stage renal disease (ESRD) requiring dialysis or kidney transplant, and certain others who elect to purchase Medicare coverage.

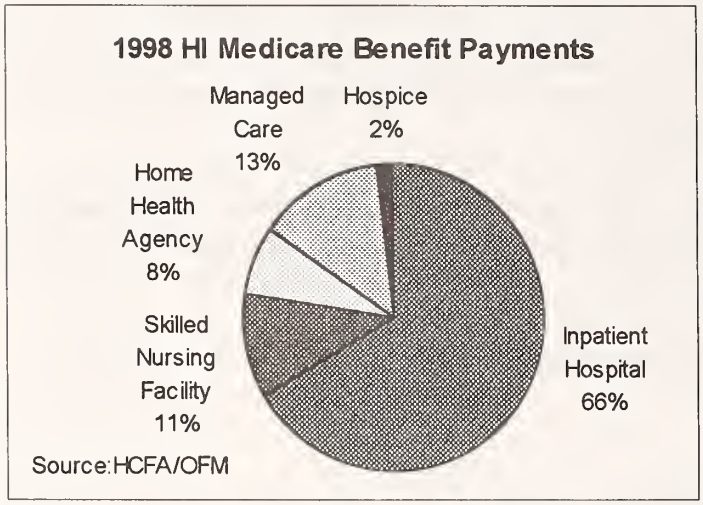


Medicare is a combination of two programs, each with its own enrollment, coverage, and financing--Hospital Insurance and Supplementary Medical Insurance. The Balanced Budget Act of 1997 (BBA)

created a third program called Medicare+Choice that provides a choice of health insurance options and, through user fees, provides funding for better consumer information. Since 1967, Medicare enrollment has increased from 19.5 million to 39.2 million beneficiaries.

Hospital Insurance

Hospital Insurance, also known as HI or Medicare Part A, is usually provided automatically to people aged 65 and over who have worked long enough to qualify for Social Security benefits and to most disabled people entitled to Social Security or Railroad Retirement benefits. HI pays for hospital, skilled nursing facility, home health, and hospice care.



The HI program is financed primarily by payroll taxes paid by workers and employers. The taxes paid each year are used mainly to pay benefits for current beneficiaries. Funds not currently needed to pay benefits and related expenses are held in the HI trust fund, and invested in U.S. Treasury securities.

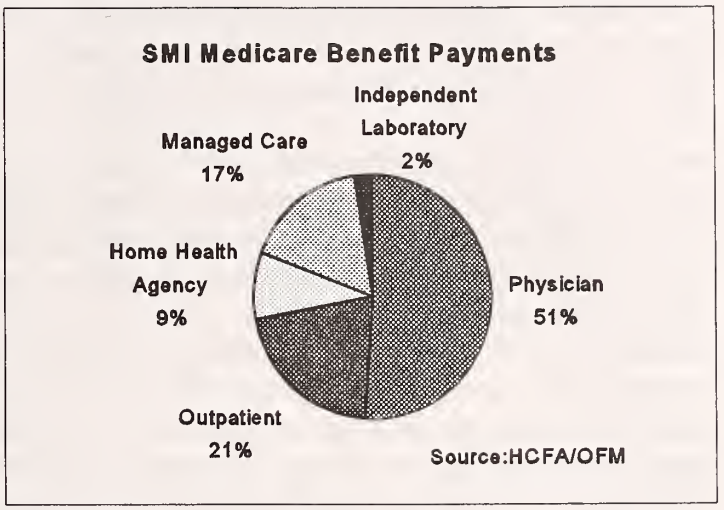
Inpatient hospital spending accounted for 66 percent of HI benefits outlays. Home health spending comprised 8 percent of total HI spending. Beginning in January 1998, the BBA re-allocated the majority of HHA spending to Part B.

HI benefits outlays fell by 3.3 percent. HI benefit outlays per enrollee dropped 4.0 percent to $3,416. However, fewer than 20 percent of HI enrollees received benefits in FY 1998--thus, spending per enrollee receiving services was much higher: $17,525.

Supplementary Medical Insurance

Supplementary Medical Insurance, also known as SMI or Medicare Part B, is available to nearly all people aged 65 and over and disabled people entitled to Part A. The SMI program pays for physician, outpatient hospital, home health, laboratory tests, durable medical equipment, designated therapy services, and some other services not covered by HI. The SMI coverage is optional and subject to monthly premium payments by beneficiaries. About 95 percent of HI enrollees elect to enroll in SMI.

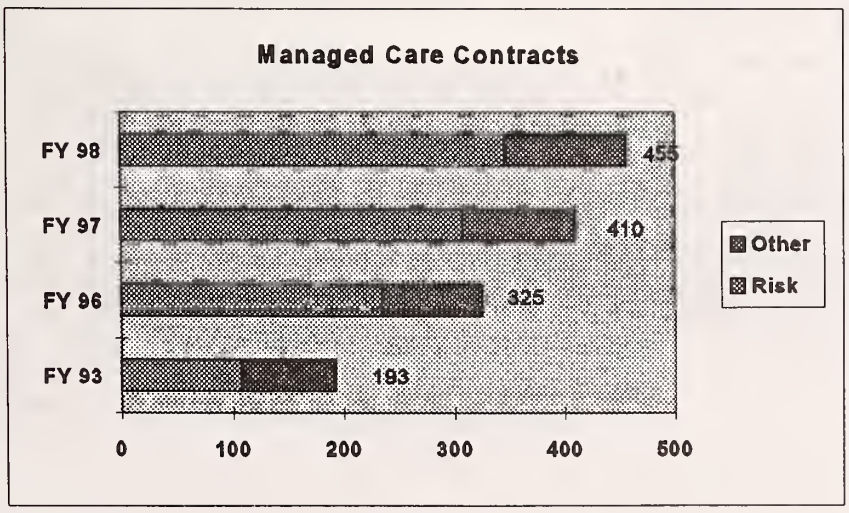
The SMI program is financed primarily by transfers from the general fund of the U.S. Treasury and by monthly premiums paid by beneficiaries. Income not currently needed to pay benefits and related expenses is held in the SMI trust fund, and invested in U.S. Treasury securities.



SMI benefit outlays grew by 12.9 percent. Physician services, the largest component of SMI, accounted for 51 percent of expenditures. SMI benefit outlays per enrollee increased 12.0 percent to $1,220. Spending per enrollee receiving services was $2,582.

Medicare+Choice

The BBA created a third Medicare program called Medicare+Choice, sometimes referred to as Medicare Part C, that, over the long-run, is expected to increase the number and type of entities (e.g., private fee-for-service plans, medical savings accounts, preferred provider organizations, and provider-sponsored organizations) that participate in Medicare. The Medicare+Choice program went into effect in January 1999. The BBA's goal is to make Medicare attractive for new entities to provide health insurance choices to beneficiaries. The BBA also restructures the capitation rates for Medicare managed care and provides for a user fee to fund a consumer information campaign to provide beneficiaries with comparative plan information beginning in 1998. The number of Medicare contracts with managed care plans increased from 165 in FY 1990 to 455 contracts in FY 1998.



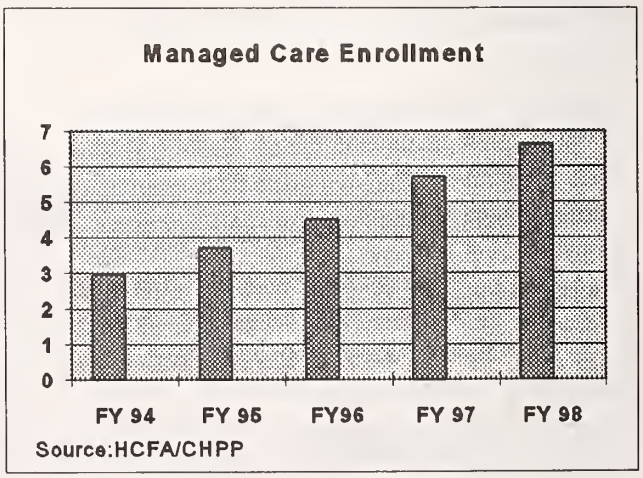
Medicare beneficiaries have long had the option to choose to enroll in prepaid health care plans (typically health maintenance organizations (HMO)

and comprehensive medical plans (CMP), commonly referred to as managed care plans) that participate in Medicare instead of receiving services under traditional fee-for-service (FFS) arrangements. In general, managed care plans have their own providers or a network of contracting health care providers (physicians, hospitals, skilled nursing facilities, etc.) that agree to provide health care services for the HMO or prepaid health plan's members.

Managed care plans currently serve Medicare beneficiaries through three types of contracts: risk, cost, and health care prepayment plans (HCPPs), as well as through certain demonstration projects. Risk plans are paid a per capita premium, assume full financial risk for all care provided to Medicare beneficiaries, and must provide, at a minimum, all Medicare-covered services. Most plans offer additional services such as prescription drugs and eyeglasses at little or no cost to beneficiaries. Cost plans are paid a pre-determined monthly amount per beneficiary based on a total estimated budget. Adjustments to that payment are made at the end of the year for any variations from the budget. Cost plans must provide all Medicare-covered services but do not always provide the additional services that some risk plans offer. HCPPs are paid in a manner similar to cost plans but generally cover only Part B Medicare services. Cost-based plans and HCPPs, with certain limited exceptions, will be phased out under the BBA provisions.

With the exception of those with ESRD, any Medicare beneficiary may join a Medicare+Choice organization if one is available in his or her area. At present, beneficiaries may disenroll at any time, with disenrollment taking effect at the end of the month. (The BBA provides for 6 and 9 month enrollment "lock-in" effective in 2002 and 2003, respectively. Enrollment periods vary, but plans are required to conduct open enrollment for at least one month per year.)

Since 1994, there has been steady growth in the number of Medicare beneficiaries enrolled in managed care plans. In September 1998, a total of 6.6 million Medicare beneficiaries, or 16.8 percent of the total Medicare population, were enrolled in a managed care plan. Managed care expenses accounted for $32.6 billion of the total $209.6 billion in Medicare benefit payment expenses in FY 1998.

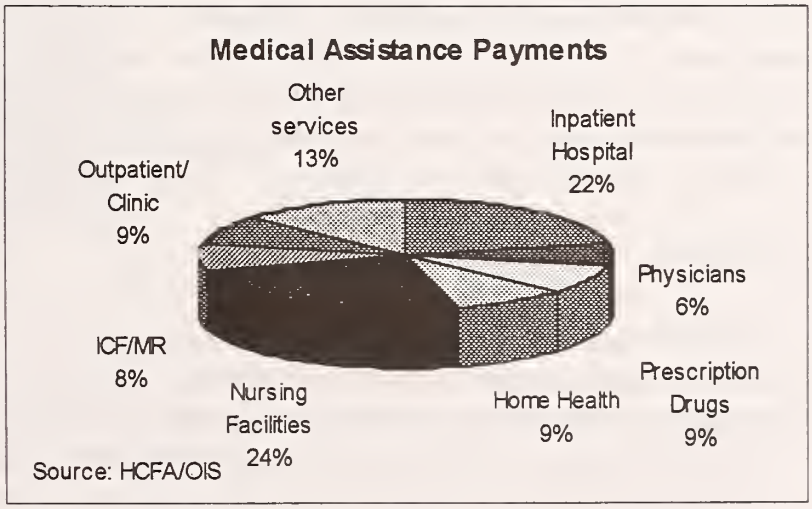


MEDICAID

Medicaid is the means-tested health care program for low-income Americans, administered by HCFA in partnership with the States. Enacted in 1965 as Title XIX of the Social Security Act, Medicaid was originally legislated to provide medical assistance to recipients of cash assistance. Over the years, Congress incrementally expanded Medicaid well beyond the traditional population of the low-income elderly and the blind and disabled. Today, Medicaid is the primary source of health care for a much larger population of medically vulnerable Americans, including poor families, the disabled, and persons with developmental disabilities requiring long-term care. The average enrollment for Medicaid was 33 million in 1998, about 12 percent of the United States population. Approximately 6 million people are dually entitled, that is, covered by both Medicare and Medicaid.

HCFA provides matching payment grants to States and Territories for Medicaid. State medical assistance payments are matched according to a formula relating each State's per capita income to the national average. In FY 1998, the Federal matching rate among the States ranged from 50 to 77 percent, with a national average of 57 percent. Federal matching rates for various State and local administrative costs are set by statute, and in 1998 averaged 56 percent. Medicaid grants are funded by Federal general revenues provided to HCFA through the annual Labor/HHS/Education Appropriations Act. There is no cap on Federal matching payments to States.

States set eligibility, coverage, and payment standards within broad statutory and regulatory guidelines that include providing coverage to persons receiving Supplemental Security Income (disabled and elderly population), low income families, the medically needy, pregnant women, young children, low-income Medicare beneficiaries, and certain other groups; and covering at least 10 services mandated by law, including hospital and physician services, laboratory tests, family planning, nursing facility services, and health screening for children under age 21.



State governments have a great deal of programmatic flexibility to tailor their Medicaid programs to individual State circumstances and priorities. Accordingly, there is a wide variation in the services offered by States.

Medicaid helps reduce infant mortality and improve maternal and infant health by bringing more eligible pregnant women into pre-natal health care and more infants into early health supervision. States can pursue these goals by expanding eligibility, streamlining eligibility processes, conducting outreach, improving provider recruitment and retention, and adding new service delivery options or enhancements.

The early and periodic screening, diagnostic and treatment (EPSDT) program is a preventive and comprehensive health program for Medicaid-eligible individuals under the age of 21. It creates a framework under which Medicaid-eligible children can receive regular preventive health screenings and a range of follow-up services that may be broader than those available to Medicaid-eligible adults.

Medicaid is the largest single source of payment for health care services for persons with AIDS. Medicaid now serves over 55 percent of all AIDS patients and pays for the health care costs of many of the children and infants with AIDS. Medicaid spending for AIDS care and treatment in FY 1998 is about $3.5 billion. In addition, the Medicaid programs of all 50 States and the District of Columbia provide coverage of all drugs approved by the Food and Drug Administration for treatment of AIDS.

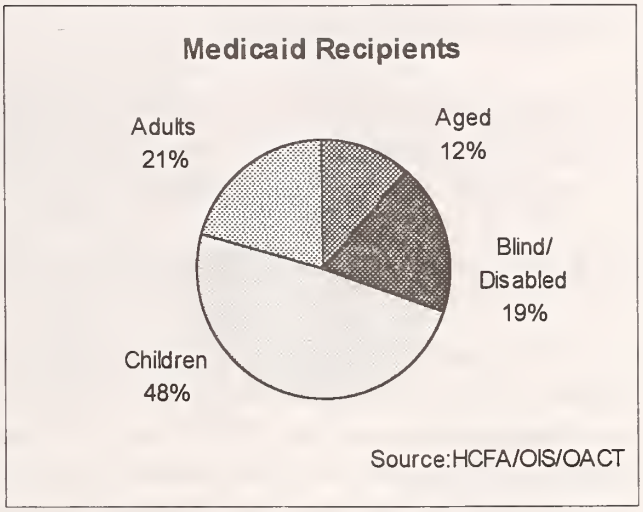
Medicaid, through its home and community-based services waiver program, provides long term care services, to hundreds of thousands of people, including the aged, disabled, technology dependent, children with particular rare diseases, persons with AIDS and respirator dependent children, in noninstitutional settings who would otherwise require costly institutional care such as provided by a nursing facility, hospital or intermediate care facility for the mentally retarded.

Payments

Under Medicaid, State payments for both medical assistance (MA) and administrative (ADM) costs are matched with Federal funds. In FY 1998, State and Federal ADM outlays were $8.5 billion--only 4.8 percent of the total Medicaid outlays. State and Federal MA outlays were $170.2 billion, or 95.2 percent of total Medicaid outlays, an increase of nearly 6 percent over FY 1997. HCFA's Medicaid expenses totaled $97.9 billion.

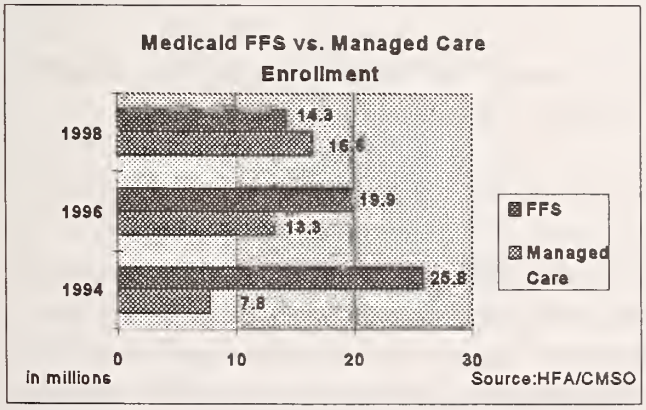
Enrollees

An estimated 35.4 million Medicaid beneficiaries received services in 1998. Children comprise 48 percent of Medicaid enrollees receiving services, but account for only 16 percent of Medicaid outlays. In contrast, the elderly and disabled comprise 31 percent of Medicaid enrollees receiving services, but accounted for 73 percent of program spending. The elderly and disabled use more expensive services in all categories, particularly nursing home services.



Service Delivery Options

Many States are pursuing managed care as an alternative to the fee-for-service (FFS) system for their Medicaid programs. Managed health care provides several advantages for Medicaid beneficiaries, such as enhanced continuity of care, improved preventive care, and prevention of duplicative and contradictory treatments and/or medications. Most States have taken advantage of waivers provided by HCFA to introduce managed care plans tailored to their State and local needs, and there are currently 48 States offering a form of managed care. The number of Medicaid beneficiaries enrolled in managed care has grown from slightly under 5 percent in 1993 to more than 53 percent by September 30, 1998.



HCFA and the States have worked in partnership to offer managed care to Medicaid beneficiaries. Medicaid law provides for two kinds of waivers of existing Federal statutes to allow for the implementation of managed care.

1) State health reform waivers - Section 1115 of the Social Security Act provides broad discretion to waive certain provisions of Medicaid law for experimental, pilot, or demonstration projects, and

2) Freedom of choice waivers - Section 1915(b) of the Social Security Act allows certain provisions of Medicaid law to be waived to allow States to develop innovative managed health care delivery or reimbursement systems.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM

One of the major provisions of BBA is a major new health insurance program for children. Implemented as Title XXI of the Social Security Act, this program was created in response to a pressing social need. Title XXI will provide health insurance, preventive health care, and other important health services to children in need through State-based programs developed cooperatively by the States and Federal government. The new State Children's Health Insurance Program is an important step forward in meeting the health needs of the nation's children and an important new responsibility for HCFA. As of September 30, 1998, HCFA had approved 41 Title XXI State plans (38 States plus the District of Columbia, Puerto, Rico, and the Virgin Islands). Of those approved, 20 were Medicaid expansions, 12 were separate State Child Health plans and 9 were combination plans.

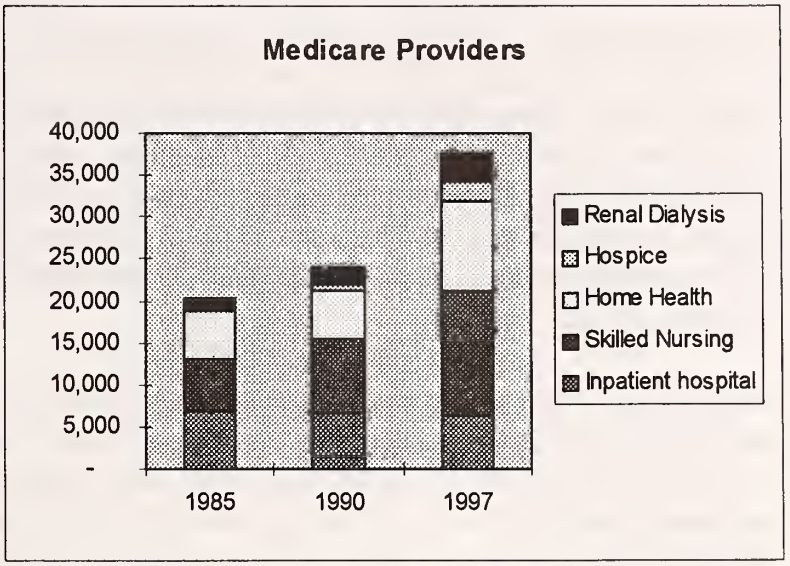
OTHER HCFA ACTIVITIES

In addition to making health care payments on behalf of our beneficiaries, HCFA makes other important contributions to the delivery of health care in the United States.

Survey and Certification Program

HCFA is responsible for assuring the safety and quality of medical facilities, laboratories, providers, and suppliers by setting standards, conducting inspections, certifying providers as eligible for program payments, and ensuring that corrective actions are taken where deficiencies are found. The Survey and Certification program is designed to ensure that providers and suppliers comply with Federal health, safety, and program standards. HCFA administers agreements with State survey agencies to conduct onsite facility inspections. Funding is provided through the Program Management and the Medicaid appropriations. Only certified providers, suppliers, and laboratories are eligible for Medicare or Medicaid payments.

There has been an overwhelming growth in providers with the largest increases in skilled nursing facilities, home health agencies, hospices, and end-stage renal dialysis facilities. Certified Medicare providers have increased from about 22,000 in 1985 to nearly 40,000 today. This total does not include the 64,000 clinical laboratories.



Quality of Care

Through Peer Review Organizations, ESRD Networks, State Agencies, and others, HCFA collaborates with health care providers and suppliers to promote the improved health status of Medicare and Medicaid beneficiaries in both FFS and managed care settings. These collaborative projects often employ a sequential process that includes setting priorities, collecting and analyzing data, identifying opportunities to improve care, establishing performance expectations, and selecting and managing one or more improvement strategies. One of the tools for improving patient care is the development and dissemination of quality indicators and the publication of performance information.

HCFA has been a leader in the use of quality indicators. Our goal is to collect measures that will help to improve the health status of our beneficiaries or help them make informed choices about their health care. Additionally, these quality indicators will assist health care providers in monitoring the care they deliver. This is an area in which we have worked very closely with the private sector, consumers, and providers to develop new tools.

Medicare+Choice broadened quality assurance and performance improvement requirements for Medicare managed care organizations. Medicare+Choice organizations will be required to meet these requirements through use of HCFA's Quality Improvement System for Managed Care, known as QISMC. The QISMC Interim Standards were released to the public in September 1998.

Coverage Policy

In today's health care market, every insurer and health care purchaser must deal with coverage policy. Private as well as public insurers, like Medicare, want to purchase high quality health care for the best price. Health plans, whether public or private, managed care or traditional indemnity plans, must control costs while still continuing to assure the highest quality of care for their subscribers. This cannot be done without authoritative evidence of the value of each individual service.

Medicare is a leader in **evidence-based decisionmaking** for coverage policy. We rely on state-of-the-art technology assessment and support from other Federal agencies, as well as the advice of the medical community and private sector studies. Our own extensive payment data contain additional useful information that is used by the Agency for Health Care Policy and Research (AHCPR) and others for assessing the effectiveness of a variety of medical treatments. The sheer number of beneficiaries that we serve and the wealth of information that we possess about them makes Medicare an important force in the market.

Insurance Oversight

HCFA has primary responsibility for setting standards for the **Medigap** insurance offered to Medicare beneficiaries to help pay the coinsurance and deductibles that Medicare does not cover. HCFA works with State insurance counseling offices to ensure that suspected violations of the laws governing the marketing and sales of Medigap are addressed.

HCFA is also responsible for implementing the data standards provision of HIPAA. The administrative simplification provision is aimed at reducing administrative costs and burdens in the health care industry. It requires HHS to adopt **national uniform standards** for the electronic transmission of certain health information. HCFA is working with both public and private organizations to develop the best standards possible with strong safeguards to ensure privacy of records. Although HIPAA does not mandate the collection or electronic transmission of any health information, it does require that adopted standards be used for any electronic transmission of specified transactions.

As a result of the **insurance reform provisions** of HIPAA, HCFA has assumed a new role in relationship to State regulation of health insurance and health coverage. HCFA works with the States' Commissioners of Insurance, the U.S. Department of Labor and the Internal Revenue Service to implement these provisions. The common goal is to improve access to the group and individual health insurance markets for certain eligible individuals who move from job to job, or who lose their group health insurance coverage and must purchase coverage in the individual insurance market. These new consumer protections affect an estimated 160 million individuals.

Performance Goals

The Government Performance and Results Act (GPRA) of 1993 requires Federal agencies to prepare 5-year strategic plans setting out long-term goals and objectives, Annual Performance Plans (APP) committing to short-term performance goals, and Annual Performance Reports explaining and documenting how effective the Agency's actions have been at achieving the stated goals.

HCFA's performance measurement approach is based on two principles: (1) The most important things to measure relate to ensuring that HCFA's beneficiaries receive the high quality care they need; and (2) the measures will be representative of program performance, because of the enormous scope of HCFA programs.

The APP describes HCFA's performance goals, their linkage to longer-term strategic goals and to the budget, as well as the steps planned and underway to accomplish each goal. The plan also establishes a method and data source for measuring and reporting on each goal. The FY 2000 performance plan includes 30 significant performance goals for HCFA programs designed to provide coverage of major program areas and budget categories.

All HCFA performance goals relate to important outcomes such as improved beneficiary health and satisfaction, sound fiscal management of one of the largest budgets in the Federal government, and maximum use of appropriate technology to improve service, achieve productivity, and minimize cost. The plan contains performance goals relating to improved use of information technology; effective implementation of Medicare+Choice and other BBA provisions; millennium readiness; reduction in fraud and erroneous Medicare payments; and improvements in quality of care oversight and customer service. It reflects key Administration and Agency priorities for the next several years. HCFA's performance goals reflect a sensitivity to customer needs and an awareness that meeting those needs will require flexibility and imagination as well as sound business sense. The APP helps focus our attention on steps to accomplish our objectives and goals.

The APP describes our joint efforts with other organizations inside and outside of government that will be necessary to meet the annual performance targets. The data sources for each individual goal, as well as particular data concerns or limitations, and the process for data validation and verification are also discussed. The APP goals reflect Agency priorities and are fully supported by managers and staff at all levels.

The Office of Management and Budget (OMB) granted HCFA a 1-year waiver of GPRA rules for the Medicaid program for the FY 1999 APP. This was needed to allow time for the Agency to continue a consultation process with State Medicaid officials aimed at producing performance goals of mutual interest. During 1998 HCFA and the States jointly developed a new Medicaid goal that commits HCFA and the States to increase childhood immunization rates over the next several years. A number of other Medicaid-related goals included in this APP were carried over from the FY 1999 plan in consultation with Medicaid State Directors.

Consistent with GPRA principles, HCFA has focused on identifying a set of meaningful, outcome-oriented performance goals that speak to fundamental program purposes and to the Agency's role as steward of many billions of taxpayer dollars. The Agency is confident that performance measurement under GPRA will contribute substantially to improvement in HCFA's programmatic and administrative performance. We anticipate that performance measurement results will provide a wealth of information about the success of HCFA's programs, activities, and initiatives. This information will be useful in making policy and management choices in both the short and long term.

Initiatives/Accomplishments

HCFA had two over-arching initiatives during 1998, the effort to bring our systems into millennium compliance, and the implementation of BBA provisions.

Year 2000 (Y2K) - the Millennium

In 1998 and continuing into 1999, HCFA's number one priority is meeting the Year 2000 challenge, also known as Y2K. The Agency's goal is to ensure that, on January 1, 2000, Medicare and Medicaid beneficiaries experience no interruption in services, and that providers continue to receive prompt and efficient payment for their services.

The Y2K problem presents one of the greatest information systems challenges since the inception of the Medicare program. It requires identifying and renovating all computer and information systems that might have Y2K problems. It also requires testing the renovated systems multiple times to make sure the new corrections will work. If not fixed, providers could receive delayed payments and incur cash flow problems. Because of this imperative, Y2K activities must take precedence over other projects that require changes to computer and information systems. Postponing other projects is necessary to focus resources and "freeze" systems so essential systems work can be done.

HCFA relies on numerous internal and external systems to pay claims to providers for furnished services. The systems also determine the eligibility of beneficiaries. All of these systems used by HCFA and at the 80+ contractor sites have complicated interfaces. And the contractors' systems ultimately interface with those used by providers. Each of the individual systems and all of their interfaces must be thoroughly reviewed, renovated for Y2K compliance, and tested. About 49 million lines of code must be renovated.

HCFA has identified 25 internal mission critical systems and 86 internal non-mission critical systems that need to be renovated for the millennium. Our goal was to have all the mission critical systems self-certified by December 31, 1998, and all other systems self-certified by March 31, 1999. We achieved our goal for the HCFA internal mission critical systems for the December 31, 1998 deadline, and have already certified 56 of the 86 non-mission critical systems.

In 1998, we set up special teams of employees whose sole responsibility is making Y2K fixes. We hired retired federal programmers to assist with Y2K efforts, and special contractors to make sure Y2K fixes are done right and to independently test systems to make sure they work properly. We amended agreements with the Medicare fiscal intermediaries and carriers to ensure that they use information technology that is Y2K compliant, tracked contractor progress to ensure that work is on schedule, and created a special contingency planning unit to make sure disruptions do not result from any unexpected problems. We also worked with the Congress to obtain and direct extra funds to this effort. HHS has estimated that the total cost for ensuring HHS systems are Y2K compliant is $781 million over FY 1996 and FY 2000. To help the Medicare Program meet the Secretary's goal of achieving full Y2K compliance, HHS allocated an extra $42.1 million to HCFA in FY 1998 by drawing on discretionary funds from each HHS operating division, increasing total HCFA spending to $148 million. In FY 1999, HHS is receiving $282 million in emergency funds for Y2K conversion, $205 million of which is targeted for HCFA, providing total HCFA FY 1999 spending of $288 million.

Work at HCFA and its contractors is well underway. All systems have been assessed and those in need of renovation have been identified. All HCFA internal systems and 95 percent of the Medicare contractor systems have been renovated, and self-certification testing to verify that they will function properly is nearing completion.

The task is enormous. Any change in payment policy requires significant systems changes. Even some seemingly simple changes can require an analysis of thousands of lines of computer code and a review of multiple complex interfaces. The more complicated payment changes involve more systems and thus more searches for problems, remediation, and testing.

Because of the enormity of this process, independent validation and verification experts recommended that HCFA require contractors to concentrate their efforts and resources exclusively on achieving Y2K compliance and maintaining minimum program operations. "Parallel" changes in contractor systems, such as those required in order to implement some provisions of the BBA were examined carefully to determine their impact on the Y2K initiative. In addition, some systems must be frozen to effectuate testing until Y2K compliance can be assured. In April, final transitions to the shared, uniform systems for Medicare contractors were postponed to devote those programming resources to Y2K compliance.

HCFA has also assembled a contingency planning group in the event that some business interruptions occur, either because of the failure of HCFA systems, the failure of some of our business partners such as providers or financial institutions, or environmental failures. The issue of data exchanges will complicate the millennium issue for HCFA since the agency must consider what could happen to exchanges of data with contractor systems and organizations that interface or exchange data with contractor systems, i.e. States, providers, RRB, etc. In these cases, HCFA is continuing to explore ways to bring the noncompliant data into a format that can be used by systems that have already been converted. The most likely business interruption scenario is the failure of providers to ensure that their systems are Y2K compliant, potentially interrupting their claims and payment transactions with HCFA. HCFA is implementing the Y2K-compliant version of all claims and payment electronic data interchanges (EDI) to ensure that its partners are able to process Y2K compliant transactions with HCFA. Currently, 95% of individual provider claims and 19% of the institutional claims are submitted using the Y2K compliant EDI formats. As a contingency, we are also instructing our contractors to implement bridges that will accept and send non-compliant EDI formats to and from providers so that payment will not be interrupted.

Implementation of BBA

A number of major actions required by the BBA do not involve Medicare contractor systems and, therefore, are unaffected by the Y2K conversion. Examples of these include some aspects of the Medicare+Choice program, such as evaluation of the adjusted community rate and implementation of new quality assurance mechanisms.

Also, most of the other 300+ BBA provisions affecting HCFA do not have to be delayed because they are completed, or can be completed before the major systems architecture must be frozen for Y2K. Examples of these include routine payment updates for 1999 including inpatient hospital coding and price changes, implementing the resource-based practice expense system, paying outpatient rehabilitation therapy services using the physician fee schedule, and new prevention benefits and other coverage requirements (e.g., diabetes test strips, bone mass measurement).

However, some provisions of the BBA may be postponed, especially those that involve extensive computer and information system changes or that were scheduled for implementation during the time that systems must be frozen. Examples of provisions that may not be implemented timely are calendar and FY 2000 payment updates, hospital outpatient prospective payment (will continue to pay under current methods), and home health prospective payment. If Y2K renovations are completed ahead of schedule, we will make every effort to place these provisions back on their original timetable.

The following Initiatives and Accomplishments are grouped by HCFA's Strategic Plan goals.

Goal 1 - Protect and Improve Beneficiary Health and Satisfaction

HCFA has defined "quality of care" as the "extent to which health care and health-related services result in desired outcomes and greater satisfaction with care for the populations and individuals we serve." This definition of quality of care and the mission statement serves as the Agency's foundation for developing an integrated quality program framework.

Beneficiary Rights & Protections

The President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry issued a paper on the Consumer Bill of Rights and Responsibilities (CBRR) in November 1997. This document calls for a national effort to improve and sustain the quality of health care in the United States. We are working to ensure that health care programs are providing the full range of rights and protections to the recipients and beneficiaries of such programs. Two recently published regulation proposals establish new requirements for organizations participating in Medicare and strengthen protections for Medicaid beneficiaries enrolled in managed care arrangements. By the end of 1999, when both regulations are fully implemented, Medicare and Medicaid will be in substantial compliance with the CBRR provisions.

Other protections in the CBRR include the right of redress through appeals, grievances, and complaints. For example, a Grievance Procedures and Appeals Data Collection Workgroup identified areas for quality improvements and new dispute resolution processes and procedures.

Medicare + Choice

The newly created Medicare+Choice program works to ensure beneficiaries will be provided with quality services and information. HCFA developed comprehensive directions for organizations regarding the new Medicare+Choice eligibility, election and enrollment procedures. In addition, we undertook nationwide campaigns to educate providers, plans and

groups on the new eligibility and enrollment provisions. Comprehensive information was disseminated via the Internet to ensure that plans and advocacy groups receive new policies promptly, and to increase beneficiaries' program knowledge and their awareness and utilization of rights and protections. We improved customer services to beneficiaries through creation of an additional disenrollment process, which is to be tested on the Medicare+Choice help line. In addition, information gathered from these disenrollments will provide insight into reasons for beneficiary disenrollment, allowing for constant improvement in the services that beneficiaries receive.

Health Promotion and Prevention

With the passage of the BBA, Medicare will pay for part or all the cost for routine screenings for breast, cervical, vaginal, and colorectal cancers. Benefits for bone-mass testing began July 1, 1998, and prostate cancer screenings start in 2000. In addition, new benefits for diabetics are aimed at encouraging all diabetics to self-monitor their blood glucose levels more frequently by paying for monitoring equipment and testing strips.

HCFA and the National Cancer Institute are working together to increase the awareness of the importance of regularly scheduled mammography screening among women ages 65 and older, and the expanded Medicare benefit. Our goal is to increase the number of Medicare beneficiaries who receive a mammogram to 60 percent.

In 1998, HCFA and the Centers for Disease Control and Prevention began efforts to promote the importance of early detection of colorectal cancer through various screenings and to raise awareness of the new Medicare covered benefit of these screenings. A national campaign will kick off in February 1999.

HCFA, in partnership with the National Diabetes Education Program is developing a promotional campaign to make beneficiaries aware of the availability of Medicare's expanded coverage and of the benefits of improved glucose control. The phrase "Control Your Diabetes For Life" emphasizes that improved glucose control prevents or delays complications associated with diabetes. The expanded Medicare benefits, glucose monitors and testing strips, and diabetics self-management training, directly impact on glucose control in both insulin using and non-insulin using diabetics.

State Children's Health Insurance Program (CHIP)

HCFA is working to ensure that CHIP is integrated with Medicaid and other State child health programs and reaches eligible children with the right balance of Federal standards and State flexibility. Beginning in FY 1998, Section 2104 of BBA and subsequent technical amendments provides for nearly $40 billion in federal funds over 10 years for CHIP. The

purpose is to enable States to initiate and expand child health assistance to uninsured, low-income children. Such assistance should be provided primarily through either or both of two methods: (1) a program to obtain health insurance coverage that meets requirements in Section 2103 of the BBA relating to the amount, duration, and scope of benefits; or (2) expanding eligibility for children under the State's Medicaid program. In order to be eligible for funds, States must obtain approval from HCFA for a State Child Health Plan. The first option is a capped entitlement and all funding stops when the State reaches its allocation.

It is the charge of HCFA to guide the States through the various stages of implementing CHIP to insure State Plan approval in a timely manner so that Federal funds are made available to the States to care for the Nation's most vulnerable population. HCFA provided the States a procedure for plan submittal, developed financial reporting forms and claims procedures, coordinated with Medicaid expansions for children's health, and developed procedures for annual reports, evaluations, and studies. The States were advised of their allotments for Federal fiscal year 1998 and States with approved plans were issued their FY 1998 allotments.

Defining Beneficiary Needs

The Medicare Current Beneficiary Survey (MCBS) helps HCFA ensure that its programs and services respond to the health care needs of our beneficiaries in a number of ways. It is the only comprehensive source of information on the health, health care, socioeconomic, and demographic and other characteristics of aged, disabled, and institutional Medicare beneficiaries. The MCBS helps HCFA in monitoring and evaluating the health care needs of Medicare beneficiaries. It directly involves beneficiaries in defining their health care needs by interviewing a large representative sample of them about their health status and physical functioning, access to care, and satisfaction with the Medicare services they use. MCBS aids in HCFA's educational and outreach initiatives by collecting information to determine which methods are best suited to reaching specific subgroups of the Medicare population, and what the communication preferences are for the general Medicare population and several specific subgroups.

HCFA is conducting market research and has completed the inventory work of documenting what is known about beneficiary information needs and communication preferences for the general Medicare population and several specific subgroups. The majority of focus groups have been completed for these same populations and the MCBS data were gathered during the spring of the year. Draft reports of results from these activities are becoming available and we have begun to distribute the findings to the Agency. We have also received reports of findings from work with providers and other partners.

Quality Improvement Assessment System and the Geriatric Telephone Survey

The Quality Improvement Assessment System (QIAS) will provide state-level estimates of various quality indicators (QI) associated with HCFA's national clinical priorities. This system will provide the basis for measuring the impact of HCFA's Peer Review organizations (PROs) in each state or territory. To accomplish this, a surveillance system is being developed that can provide unbiased estimates of those indicators across both fee-for-service and managed care providers within each State. As currently envisioned, QIAS will sample HCFA inpatient claims - from both the PRO Standard Data Processing System and the managed care encounter data files - and use HCFA's Clinical Data Abstraction Centers to abstract the necessary quality indicator data from inpatient records.

Inpatient record data will be supplemented with Part B claims data from the National Claims History and survey data from a national geriatric telephone survey for Medicare beneficiaries, for the QIs which are not associated with inpatient treatments such as influenza and pneumococcal pneumonia immunizations and mammography utilization. A pilot of a possible survey instrument and survey methodology was completed in October 1998.

Beneficiary Outcomes

In June 1998, HCFA implemented a National Minimum Data Set for nursing home residents to track the outcomes of services to nursing home residents. This data will be integrated into the Medicare/Medicaid inspection and certification process and will serve to validate payments under nursing home PPS. Efforts are now underway to develop similar systems for home health and other procedures under BBA.

Nursing Home Initiative

In July 1998, a new nursing home initiative was implemented. This initiative provides enhanced protections for nursing home residents. It targets needed improvement in nursing home quality through more frequent inspections for facilities that repeatedly violate quality standards and staggered inspections on weekends and evenings to ensure uniformity in the quality of care.

Medicare Consumer Assessment of Health Plans Study (CAHPS)

The CAHPS is an initiative to collect and report objective information to help consumers and purchasers assess and choose among managed care plans. A Medicare Satisfaction Survey was developed that contains a core CAHPS questionnaire applicable across different health care delivery systems (commercial insurance, Medicaid, and Medicare

managed care) along with supplemental questions relevant to the Medicare population. In addition, HCFA will use information on beneficiary satisfaction and access for monitoring and quality improvement purposes.

Goal 2 - Promote Fiscal Integrity of HCFA Programs

The passage of the HIPAA and the BBA has a tremendous impact on the fiscal integrity of HCFA's programs. Implementation of the provisions contained in these laws will provide continuing impetus toward sound financial management and the elimination of fraud, waste, and abuse in Medicare.

Program Integrity Activities

The Medicare contractors carry out a range of activities collectively known as "payment safeguards" to prevent, detect, and recover inappropriate Medicare fee-for-service benefit payments. Over the past several years, these payments have returned significant savings to the trust funds. Payment safeguards include:

- Medicare Secondary Payer (MSP)--activities that identify instances where an insurance company may be the primary payer, prior to payment of the claim by Medicare or as a recovery after payment by Medicare,
- Medical Review and Utilization Review (MR/UR)--activities that ensure medical services provided are covered by Medicare and are reasonable, necessary and appropriate,
- Audits of Medicare providers, including health maintenance organizations,
- Fraud and abuse detection and prevention.

The BBA builds on the anti-fraud and abuse provisions of HIPAA and gives HCFA more authority through its anti-fraud and pro-efficiency measures. Under this new law, HCFA has more authority to keep dishonest health care providers out of the Medicare program, exclude providers who are found to be abusing the program, and impose monetary penalties on providers as necessary.

The Program Integrity Strategy

HCFA has made great strides in 1998 to further define its overall strategy for fighting fraud and abuse in the Medicare and Medicaid programs. In March of 1998, HCFA sponsored a national fraud, waste and abuse conference in order to gather industries and sectors together

and share best practices for fighting fraud and abuse. We were encouraged to learn that we already take advantage of many of the fraud and abuse preventive practices currently used by others in the public and private sectors.

In order to build on the lessons learned during the March conference, HCFA has created a Program Integrity Comprehensive Plan. Our program integrity strategy as defined in the Comprehensive Plan focuses on four key payment safeguard principles that help promote the fiscal integrity of HCFA's programs. These principles make up our strategy for combating fraud and abuse in the Medicare and Medicaid programs: Prevention, Detection, Enforcement, and Coordination.

Fraud prevention means paying right the first time through such measures as changing Medicare payment methodologies to make it harder for fraud to occur, keeping convicted criminals out of the program, requiring providers to post surety bonds, and collecting information, such as Social Security Numbers and Employer Identification Numbers, to track abusive providers. **Detection** means catching and recovering improper payments quickly by analyzing our data, monitoring utilization trends, and following-up on beneficiary reports of improperly paid claims. **Enforcement** means taking action against those who abuse the Medicare and Medicaid programs through administrative remedies. These include suspending payments, collecting overpayments, disenrolling bad providers, imposing civil monetary penalties, and/or referring cases to the OIG. **Coordination** means applying the principles of Operation Restore Trust (as discussed below), providing case support for law enforcement, developing fraud alerts and fraud databases, and working with beneficiaries and providers to stop fraud and abuse.

Our Program Integrity Comprehensive Plan also discusses our short-term initiatives. These initiatives focus on program management improvements and on service specific areas which are particularly vulnerable to fraud and abuse. The program integrity initiatives as defined in the Comprehensive Plan are as follows:

- Increasing the effectiveness of our medical review and benefit integrity activities;
- Implementing the Medicare Integrity Program;
- Implementing payment safeguards for new Balanced Budget Act provisions;
- Promoting provider integrity;
- Initiating millennium contingency planning for program integrity activities; and,
- Addressing service specific vulnerabilities in:
  --inpatient hospital care;
  --congregate care;
  --managed care;
  --community mental health center care; and,
  --nursing home care.

Operation Restore Trust (ORT)

Launched by President Clinton in May 1995 as a five State demonstration project, ORT has expanded into an extremely powerful vehicle to help fight fraud, waste and abuse in the Medicare program. It has rapidly become the way that we do day-to-day business throughout our agency because of its overwhelming success. Cultivating partnerships among interdisciplinary teams of Federal, State and local Government representatives, the ORT projects have targeted Medicare abuses throughout the United States. In its first two years, ORT identified more than $200 million owed to the Federal Government by various providers. Expanding to several more states in 1997, the ORT initiative further identified approximately $98 million in inappropriate payments to providers. Overpayments for ORT 1998 are still being identified, but are expected to be comparable to previous years.

Other Anti-fraud Initiatives

HIPAA includes a provision establishing the "Medicare Integrity Program." This provision gives HCFA specific authority to enter into contracts with entities to promote the integrity of the Medicare Program. Therefore, Medicare can now competitively award contracts to firms who demonstrate their capability to undertake specific activities such as medical reviews, to ensure that services billed to Medicare were medically necessary; fraud detection, prevention; and case development for referral to law enforcement agencies. These new contractors, known as program safeguard contractors (PSCs) will help HCFA continue to fight fraud, waste and abuse in the Medicare Program and protect the integrity of the Trust Funds.

The PSC initiative will enable fiscal intermediaries and carriers to focus on their main business of processing claims, while establishing separate organizations that can focus on program safeguard activities. Separating program safeguard activities from the mainstream of claims processing operations is a solution to a potential conflict of interest, and a prudent business practice. The PSC initiative will also allow for a competitive process, ensuring the highest quality for the best price, appropriate clinical personnel, a reduced number of contractors handling program safeguard activities thereby increasing efficiency and effectiveness, and increasing the consistency in operations and application of Medicare coverage and coding rules.

Medicaid Initiatives

HCFA, under the **National Medicaid Fraud and Abuse Initiative**, will continue to assist the OIG, the State Medicaid Fraud Control Units (MFCU), and Program Integrity Units in their role of prosecuting fraudulent providers; ensure all States are aware of fraudulent activities and scams occurring nationwide; promote consistency by establishing enhanced

communications systems; form a National Fraud and Abuse Technical Advisory Group composed of HCFA and State agencies; and, develop a model legislative fraud and abuse package for States that builds on the best practices of States who already have similar legislation.

HCFA has also placed greater emphasis on Medicaid fraud through formation of the Medicaid Fraud and Abuse Coordinating Council and the Medicaid Regional Office Network. These projects help coordinate increased cooperation with States and other entities. HCFA's partnerships with States' Surveillance and Utilization Review Systems and MFCUs have facilitated detection, referral, and prosecution of Medicaid fraud.

Medicare Secondary Payer (MSP)

If Medicare records fail to show when a beneficiary has other insurance, Medicare can mistakenly pay claims that should have been paid by the primary insurance company. HCFA has undertaken a number of initiatives to avoid incorrect payments in this situation. The Initial Enrollment Questionnaire solicits data about other primary health insurance coverage from newly enrolled Medicare beneficiaries. A data match, in collaboration with the Internal Revenue Service and the Social Security Administration, is used to develop leads where Federal tax returns show wages reported for beneficiaries or their spouses who might have group health insurance and for whom Medicare is paying for health care services. In September 1998, HCFA took the first steps to consolidate activities that support the collection, management and reporting of MSP data for Medicare beneficiaries who have other insurance coverage under one contractor. This is expected to yield administrative and programmatic efficiencies in the agency's management of its benefit coordination function.

Prospective Data Sharing is an initiative involving agreements with employers and major insurance companies to exchange enrollment information that permits us to identity MSP situations. Over the last few years, with the assistance of the HHS and DOJ attorneys, HCFA has negotiated litigation settlements with several private health insurers to address their noncompliance with MSP provisions of the law. One aspect of these settlements involves quarterly exchanges of information with private health insurers so that beneficiaries' files can be annotated with MSP information. In September 1998, HCFA entered into its first voluntary data match agreements with two Fortune 500 companies to exchange Medicare and employer group health plan eligibility information. This type of agreement will reduce the number of instances where Medicare must "pay and chase" recoveries where beneficiaries have other coverage which is primary to Medicare.

Goal 3 - Purchase the Best Value Health Care for Beneficiaries

HCFA is the largest purchaser of health care in the United States, and is transitioning from a payer organization to a "prudent purchaser of health care services." This transition is being made through collaboration with a number of large purchasers to explore opportunities for obtaining the best value in quality, cost-effective health care services for our beneficiaries. To that end, we have created an external customer profile, a new, user-friendly system that will enable HCFA to deal with our provider groups and advocacy communities and will enhance coordination of customer correspondence, report gathering and research.

Along with other large purchasers of health care, we are developing purchasing strategies that will help us not only meet our goal of providing high quality health care to both Medicare and Medicaid beneficiaries, but also provide the best value in services for the dollars we spend for both managed care and fee-for-service. This is vital in view of the current funding situation.

Medicare+Choice

It has long been a credo of Medicare that beneficiaries should have a wide range of choices to meet their health care needs, whether through managed care or fee-for-service. The BBA contains the most sweeping changes for Medicare managed care since the program's inception. Beginning in 1999, the new "Medicare + Choice" program allows additional types of entities to participate in Medicare and could, over the long-run, increase the number of health insurance options available to beneficiaries. HCFA continues to be particularly interested in the growth of health insurance options in rural and other underserved areas of the country.

Medicare+Choice plan types under the BBA will include coordinated care plans (e.g., Health Maintenance Organizations and Competitive Medical Plans both of which were previously allowed to participate in Medicare, as well as Preferred Provider Organizations and Provider Sponsored Organizations), religious fraternal benefit society plans, private fee-for-service-plans, and medical saving accounts, for which the BBA authorizes a special demonstration for up to 390,000 beneficiaries.

Other Value-Based Initiatives

HCFA is currently conducting several other major initiatives and demonstrations which can help make HCFA a more prudent purchaser of services by incorporating innovative payment approaches while fostering the provision of quality health care. Two examples are:

- The durable medical equipment (DME) Competitive Bidding Demonstration will use market forces to set prices for specific categories of DME products in up to three sites.

- Under the Competitive Pricing Demonstration, payments to managed care plans in specified areas will be determined by a competitive pricing methodology.

Activities to Assist in Value-Based Purchasing

HEDIS® - In 1996, we worked with the National Committee for Quality Assurance (NCQA) to adopt a system of quality measures called HEDIS®, the Health Plan Employer Data and Information Set, to create measures that could be adapted to Medicare and Medicaid. The result was HEDIS® 3.0. In 1998, we required more than 250 Medicare managed care risk and cost contractors to report measures from HEDIS® 3.0 to the NCQA. These measures included effectiveness of care, use of services, access to care and other areas where we thought it important for HCFA as the largest purchaser of health care to have a better understanding of the performance of Medicare managed care plans.

We also contracted with the Island Peer Review Organization (IPRO) to conduct a validation of selected measures each year. We are currently analyzing both the HEDIS® data submitted by the plans, and the results of IPRO's audit as we determine the best ways of using HEDIS® in improving quality of care and in providing consumers with information in choosing among plans. HCFA intends to combine HEDIS® measures with other information that HCFA collects about health plans, such as beneficiary satisfaction, physician reimbursement arrangements, and disenrollment. For Medicaid, the States have the option of using those HEDIS® measures that are most appropriate for their populations. HCFA is also exploring the feasibility of calculating selected effectiveness of care measures for its fee-for-service population.

Healthy Aging

In cooperation with other components of HHS, HCFA has developed the Healthy Aging Project to identify what works to promote health and prevent functional decline in the elderly population. The RAND Corporation in Santa Monica, California has been awarded a contract to conduct the activities of this project, which include producing two evidence reports and conducting two pilot interventions. The first report will gather the evidence on interventions that promote the use of Medicare preventive benefits, such as immunizations, colorectal cancer screening and mammography. The second report will gather the evidence on behavioral risk factor reduction interventions, such as arthritis self-management, health risk appraisals combined with targeted interventions to reduce risk factors, smoking cessation strategies, and home-based geriatric assessments to reduce falls and nursing home admissions.

The contractor will test behavioral risk factor reduction interventions most relevant for Medicare programs, policies or delivery systems. These interventions will be tested with beneficiaries in managed care and fee-for-service.

The Health Plan Management System (HPMS)

The HPMS is a plan-level database that will include all available data on each Medicare + Choice contract. The system will support analysis and decision making and enhance several value-based purchasing activities such as the beneficiary information campaign, performance measurement, quality improvement efforts, and monitoring activities.

Quality-related Initiatives

HCFA is working with the Foundation for Accountability (FACCT), a nonprofit organization dedicated to helping purchasers and consumers obtain the information they need to make better decisions about their health care based on quality. FACCT plans to provide education to help the public make informed decisions when choosing a health plan. HCFA is interested in FACCT's ability to integrate the perspectives of people who buy and use health care into quality of care measurement. FACCT endorsed three condition-specific outcome measures and a consumers' information strategy which HCFA is interested in testing. The measures are diabetes, depression, and breast cancer. FACCT's consumer oriented perspective provides a necessary counterpoint to provider-oriented quality assurance organizations.

Diabetes Quality Improvement Project

Persons with diabetes need regular screening tests to prevent and limit the many serious complications of the disease, ranging from vision and vascular problems to kidney disease. The Diabetes Quality Improvement Project is a national effort, initiated and funded by HCFA, to achieve consensus around a comprehensive set of performances measures for care for patients with diabetes. The project collaborators, American Diabetes Association, the American College of Physicians, the American Academy of Family Physicians, the Foundation for Accountability in Health Care, the National Committee for Quality Assurance, and the Veterans' Health Administration released the first set of measures in July 1998. These measures provide a baseline for quality improvement and will allow valid comparisons of care across health care systems.

Cooperative Cardiovascular Project (CCP)

The diagnosis code "heart failure and shock" continues to lead the list of reasons for Medicare treatment. The CCP is a national project that addresses the quality of hospital care for Medicare patients with heart attacks. The CCP focuses on improving hospital performance

in the areas of heart attack treatment or preventive measures such as thrombolytics (clot busters), aspirin, and beta blockers. Peer Review Organizations (PROs) provide hospitals with individualized feedback on CCP performance measures (or quality indicators). Preliminary results have shown an improvement in all CCP quality indicators, a decrease in length of stay, and a 10 percent drop in mortality rates for heart attack patients. The PROs have created state-specific plans for follow-up samples and reinforcement of the improvement activities in 1997 and 1998. More detailed information and data charts are available at —www.usccp.org.

End Stage Renal Disease (ESRD) Initiatives

As the single largest purchaser of ESRD treatment services in the United States, HCFA has a critical responsibility for the quality of care delivered to these patients. Our goal is to improve the quality and accessibility of the services, while keeping an eye on costs. We have successfully completed the fifth year of data collection and reporting by the ESRD Core Indicator Project. We are building a comprehensive, integrated approach to the quality management process for ESRD on a number of fronts by implementing a new focused survey process, revising the Conditions for Coverage, developing ESRD clinical performance measures to measure and report the quality of care for dialysis patients, enhancing the quality improvement projects of the ESRD networks, and improving the working relationships between Networks, State Agencies, and PROs with quality improvement as our goal. "It's Your Life...Know Your Number!" in an ESRD patient brochure designed to educate ESRD patients about their condition so they can determine if the hemodialysis treatments they receive are adequate.

Goal 4 - Promote Beneficiary and Public Understanding of HCFA and its Programs

The HCFA Home Page

HCFA's data bases are the largest and most complete source of health care information in the United States. In 1996, HCFA unveiled a new, expanded Internet web site —http://www.hcfa.gov— that offers data, statistics, publications (including our annual financial report), guidelines on detecting fraud, and other material for our beneficiaries, contractors, and the general public. Although many beneficiaries do not have a direct link to the Internet, beneficiary and consumer advocates, insurance counselors, and public entities who are the most frequent sources of beneficiary advice and counseling do possess this technology. In April 1998, a new web site —www.Medicare.gov— was made available. This site was designed specifically for beneficiaries with beneficiary input. We believe our beneficiaries will greatly benefit from this widely accessible and user-friendly data source. Information available is discussed below.

Comparative Information

We wish to make comparative information available to all Medicare beneficiaries to assist them in making health care choices. Currently, "Medicare Compare," the Health Plans Comparison Database, can be accessed from the websites listed above. Medicare Compare provides a wealth of information on various types of plans, allowing users to "comparison shop" for plans. Users can look up cost and benefit information in different geographic areas, such as State, County, and Zip code.

More recently, HCFA added "Nursing Home Compare," which provides quality of care information on Medicare and Medicaid nursing homes. "Nursing Home Compare" provides easy access to information about every Medicare and Medicaid-certified nursing home in the country by performing geographic searches, similar to "Medicare Compare." It includes results of onsite surveys performed by the State Survey Agencies and allows users to "comparison shop" between nursing homes.

Annual Publications

During 1998, HCFA's Medicare Handbook was distributed to all newly enrolled beneficiaries. The remaining 32.5 million beneficiaries received a copy of the "Medicare & You Bulletin," a more concise information brochure describing new prevention benefits, health plan choices, help for low income beneficiaries and phone referrals for additional information. In addition, HCFA and the National Association of Insurance Commissioners (NAIC) published the "Guide to Health Insurance for People with Medicare."

Beginning in December 1998, the Medicare Handbook was available in Spanish, audiotape (English and Spanish), and Braille. Also, an updated version of the "Guide to Medicare Supplemental Insurance" provides detailed information on purchasing and using Medigap and other types of private health insurance.

Medicare Summary Notice (MSN): In FY 1997, we began national implementation of the new and improved notice to beneficiaries when a claim is paid on their behalf. Among the many benefits of each new notice is a "Help Stop Fraud" message that is included to help beneficiaries review their notice for suspected fraud. These messages can be tailored to locality to inform beneficiaries of local fraud scams.

The MSN replaces the multiple forms used today. MSNs will be produced on a monthly basis for claims filed with the intermediary and carrier. The new MSN is designed to enhance customer understanding, make it easy to file appeals, reduce paperwork, and present data in a clear, concise format.

Reaching Out to Low-Income Medicare Beneficiaries

To help provide access to protection and health coverage for seniors, HCFA initiated a multi-faceted undertaking to increase the enrollment of low-income Medicare beneficiaries into State Medicaid programs that pay, in whole or in part, for out-of-pocket Medicare expenses (premiums, deductibles and/or coinsurance). Medicare beneficiaries with incomes up to 200 percent of the Federal poverty level may be eligible. Enrollment into the various dual eligible programs will not only relieve the financial burden of this vulnerable population, but will also significantly increase their access to health care.

Beneficiary Outreach

In order to help beneficiaries make informed choices about how they want to receive their health care and understand their options under Medicare + Choice, HCFA began the National Medicare Education Program. One component of this was the National Alliance Network that includes over 120 organizations representing employers, unions, advocacy groups, and provider associations. This group has produced hundreds of conferences, newsletter articles, foundation grants, and other initiatives in Medicare education.

HCFA also established a network of advocacy and support groups which meets quarterly to share information to enable beneficiaries to have better access to information and services. During 1998, we made advances in our ability to provide usable information, access, and appropriate services to the special needs populations. As part of this effort, HCFA initiated a policy to produce printed materials in alternative formats for the disabled and to create a separate Medicare Help line TTY/TDD phone number for our beneficiaries with hearing and speech impairments.

Goal 5 - Foster Excellence in the Design and Administration of HCFA's Programs

HCFA has embarked on a number of systems enhancements and innovations. As discussed earlier, some of these initiatives will not be implemented until Y2K compliance is assured.

Standard Systems Maintainers

When Medicare was first implemented thirty years ago, each of the Medicare contractors used its own payment system to pay claims. Legislative and other program changes had to be separately programmed for each of these systems. Over the years, the contractors began to subcontract with systems maintainers for these services, and in 1996 there were approximately eighteen maintainers. To become a more effective administrator of Medicare, we are working to consolidate the Medicare payment systems into three standard systems, one for

intermediaries, one for carriers, and a third for the durable medical equipment carriers, each with an integrated accounting system. This will simplify current operations, enable HCFA to implement change control management processes, and ensure that the highest priority changes are made first.

Because of continued problems with debt collection referrals and contractor reporting for the financial statement, we have also begun to design an overpayment tracking system and an integrated financial system that will incorporate accounting and reporting processes into the three selected standard systems. These systems changes are necessary before HCFA can achieve substantial compliance with the Federal Financial Management Improvement Act.

Data Improvement Initiatives

We are working with the States and the health care industry to implement the BBA provision requiring all States to submit claims data (including encounter data) through the Medicaid Statistical Information System (MSIS) beginning January 1, 1999. Currently more than 30 States participate on a voluntary basis. We have initiated a consultation process with the States to develop an implementation plan as well as enhanced methods for the receipt, transmission, and reporting of Medicaid data. We have also solicited input and assistance from other users, including the research community. Total participation by all States in MSIS will for the first time provide for a unique national standardized Medicaid database, reflecting an annual volume of approximately 1.5 billion records of Medicaid statistical information.

Information Technology Investment Process

In accordance with the Clinger Cohen Act of 1996, HCFA is implementing an Information Technology (IT) Investment process. At this stage of implementation, all project owners of "major" IT investments (those investments that exceed $10 million over a 5-year period, and are essential for the accomplishment of Agency business-drivers) are required to document their analyses (e.g., return on investment, risk, etc.). To be fully successful, implementation of the full process must be phased. During this transition period, resources are focused on ensuring (1) that the Agency's major investments are in compliance with the OMB guidance; and (2) that other high-priority investments, are consistent with HCFA's IT architecture. HCFA will continue to work incrementally toward full implementation of the IT investment process as we move into the FY 1999-2000 cycles.

Goal 6 - Provide Leadership in the Broader Public Interest to Improve Health

Coverage

Over the past 30 years, we have developed a coverage process that assures access to medical advances for Medicare beneficiaries, while protecting them from services whose effectiveness is unproven. One of HCFA's greatest challenges in administering the Medicare program is to maintain a dynamic decision making process that produces consistent coverage guidance in the face of rapid changes in medical technology and health care delivery.

Medicare has emerged as a leader in the move toward such evidence-based decision making for coverage policy. We rely on state-of-the-art technology assessment and on agencies such as AHCPR, the Food and Drug Administration (FDA), the National Institutes of Health (NIH), the Department of Veterans Affairs (VA), the Department of Defense (DoD) as well as the advice of the medical community and private sector studies. Our own extensive reimbursement data contain additional useful information for assessing the effectiveness of all varieties of medical care. The experience from our program can benefit the entire health care marketplace.

Furthermore, the sheer numbers of beneficiaries that we serve and the wealth of information that we possess about them makes Medicare and Medicaid an important force in the market. Medicare has been a leader with respect to developing and implementing payment policies which are now being used in the private sector. Examples include prospective payment for inpatient hospitals and the resource-based relative-value system for physician payment. HCFA is now in the process of developing prospective payment systems for other providers (e.g., home health agencies and skilled nursing facilities).

Partnering with States to Regulate Health Insurance

HCFA has long been responsible for regulating and monitoring Medigap insurance. As a result of HIPAA implementation activities for health insurance portability, HCFA has assumed a new role in relationship to State regulation of health insurance and health coverage. We work closely with the States and the NAIC to get their views and comments on the policy issues and regulatory processes. Also, we met with many other State groups, such as the National Governors' Association and the American Public Welfare Association's National Association of State Medicaid Directors.

The HIPAA provides for, among other things, improved portability and continuity of health insurance coverage in the group and individual insurance markets. The law provides for shared responsibilities for the Secretaries of HHS, Labor, and Treasury. HHS, through

HCFA, is working with the other Departments in implementing the group market provisions. In addition, HCFA has the sole responsibility for implementing and overseeing the provision of insurance protection in the individual market.

The group market provisions of HIPAA affect group health plans (generally, plans sponsored by employers or employee organizations, or both, and insurers). These HIPAA provisions are designed to improve the availability and portability of health coverage by limiting exclusions for preexisting conditions; providing credit for prior health coverage; providing new rights that allow some individuals to enroll for health coverage when they lose other coverage or have a dependent; prohibiting discrimination in enrollment and premiums; guaranteeing availability of health insurance coverage for small employers and renewability of coverage in both the small and large group markets.

HIPAA provides for the enforcement of the small group and individual market provisions by States. However, if a State fails to enforce the Federal statutory provisions and does not choose to implement an acceptable alternative mechanism, then the statute provides for Federal enforcement of these provisions. To date, three States—California, Missouri, Rhode Island—have not passed conforming legislation, thus requiring HCFA to assume enforcement responsibility. Other States have opted not to implement some aspect of the insurance reform, thus requiring the Federal Government to assume a more active role.

In 1998, HCFA issued a bulletin to States and issuers concerning insurance practices inconsistent with HIPAA's guaranteed availability provisions: agent commissions for sales to HIPAA-eligible individuals or small groups; unreasonable delays in processing applications from HIPAA-eligible individuals or small groups; and certain rating practices. HCFA has also provided technical assistance to States and others working to implement HIPAA's portability protections. HCFA also has helped hundreds of consumers resolve their HIPAA-related issues and exercise their rights under the statute.

In order to implement and enforce HIPAA provisions, HCFA, among other things, must collect and review documentation regarding policy forms for compliance, regulate certificates of prior creditable coverage, and monitor marketing of individual policies. We have been working closely with State officials so that workers and their families in these States can benefit from this law as soon as possible.

Research Activity

The goal of HCFA's research, demonstration, and evaluation program is to provide timely, reliable information required for informed and rational decision making in the Medicare and Medicaid programs.

This goal has four primary objectives: (1) To monitor and evaluate performance of HCFA programs in terms of access, quality, efficiency and costs; (2) To further refine existing payment systems and to develop new payment, cost containment, and financing systems; (3) To develop new approaches to meet health care needs of vulnerable populations; and (4) To develop information systems to improve consumer choice and health status.

Exploring Methods of Payment: Medicare

Over the years, HCFA's research activities have lead to a number of innovations in payment methodologies. Prominent examples include prospective payment for inpatient hospitals and resource-based relative value system for physician payments. The BBA included several other payment reforms based on HCFA research including risk adjustment of payments to Medicare+Choice organizations and prospective payment systems for skilled nursing facilities, home health agencies, inpatient rehabilitation hospital care, and hospital outpatient services.

Past HCFA research explored the impact of risk selection on the Medicare program. HCFA research, as well as external research, found that managed care plans tend to attract, on average, healthier beneficiaries which results in an overpayment to plans relative to what HCFA would have paid had the beneficiaries remained in FFS. HCFA research activities also focused on methods to address such selection. HCFA research continues to refine methods of health status based risk adjustment using encounter data.

In connection with long-term care, in 1997, HCFA began a study to examine and report on possible refinements to the resource utilization groups version III (RUG III) methodology for classification of skilled nursing facilities (SNFs) residents based on their predicted resource consumption. This study will examine the components of another resident classification system, the Nursing Severity Index (NSI) and determine if items contained in the NSI could improve the predictability of the RUG III system. The study will be conducted using existing resident level information and facility resource use data from a sample of SNFs in 12 States.

Exploring Methods of Payment: Medicaid

In the Medicaid arena, many States have been actively studying new ways to implement managed care to permit new service and payment designs. Medicaid's home and community-based services waiver program affords States the flexibility to develop and implement creative alternatives to institutionalizing Medicaid-eligible individuals.

Section 1115 of the Social Security Act provides broad discretion to waive certain laws pertaining to Medicaid in order to conduct experimental, pilot or demonstration projects. These demonstrations frequently finance services to more low-income and uninsured people

through new program efficiencies. Currently, 48 States offer some form of managed care expanding coverage to many persons who were previously uninsured.

User-Friendly Data

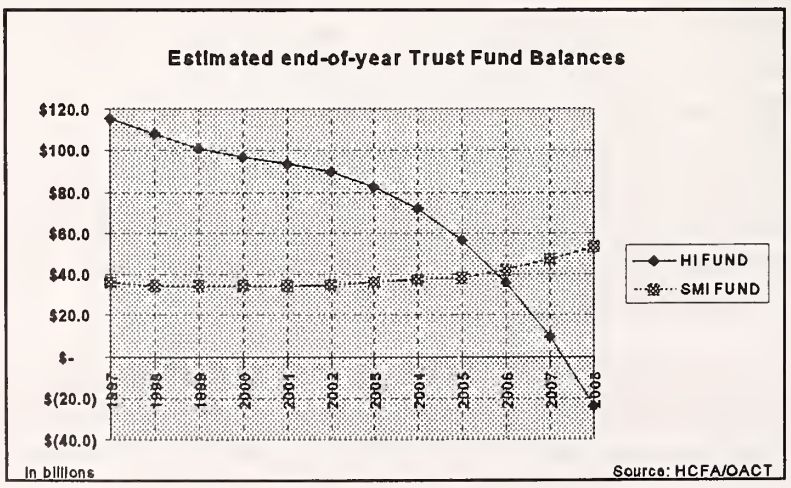
HCFA awarded the Research Data Assistance Contract (ResDAC) to the University of Minnesota School of Public Health, in a consortium with the Boston University, School of Medicine and Dartmouth College Medical School. The purpose of the contract is to increase the amount of independent research and the number of researchers skilled in accessing and using HCFA databases for studies. ResDAC is developing training databases for using population-based studies. These databases will be structured to resemble actual HCFA files. Researchers will be able to gain experience in file linking, data element selection and testing of various analytical tools, and statistical procedures. Our plans call for the eventual release of these training databases as a public use file on the HCFA Home Page.

Challenges

STATUS OF THE TRUST FUNDS

Hospital Insurance (HI)

The 1998 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund projected, under intermediate actuarial assumptions, that the HI Trust Fund will be depleted in 2008.



The Trustees (the Secretaries of the Treasury, HHS, Labor, the Commissioner of the SSA, and two public trustees) recommended the earliest possible enactment of legislation to reduce growth in the HI program costs and extend the date of exhaustion of the HI Trust Fund. The BBA remedied the imminent depletion of the HI Trust Fund. One provision funds only the first 100 home health agency (HHA) visits that are post-hospital or post-skilled nursing facilities (SNF) care from the HI Trust Fund. Other provisions change the payment process for outpatient hospital clinics, HHAs, inpatient rehabilitation hospitals, and SNFs to a prospective payment system (PPS). In 1998, we implemented the SNF PPS. The BBA also established a Bipartisan Commission on the Future of Medicare to develop long-term solutions to meet the challenges of the baby boom generation.

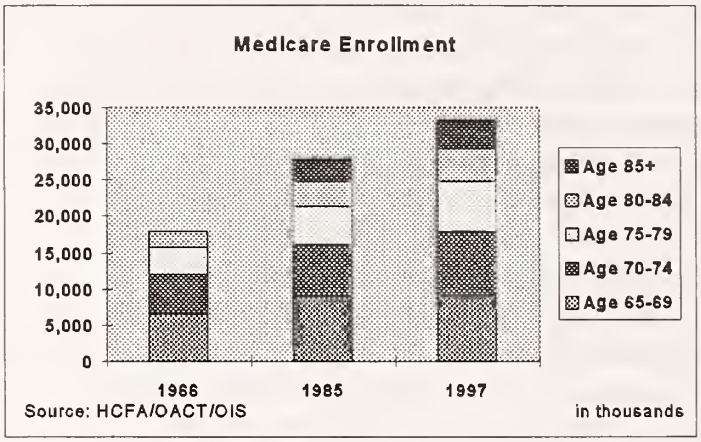
Supplementary Medical Insurance (SMI)

The SMI trust fund is expected to remain adequately financed into the indefinite future, but only because current law provides for the establishment of program financing each year based on an updated calculation of expected cost per SMI beneficiary. The BBA also remedied a provision of the law in which the premium income would cover a declining share of program costs. Premiums accounted for 24 percent of revenue in fiscal year 1998. Prior to the passage of the BBA, premiums were estimated to account for 16 percent in calendar year 2006 and a progressively lower share thereafter.

The Demographic Challenge

Demographic trends pose a long-term challenge to the sustainability of the trust funds. There are expected to be 3.6 workers per HI beneficiary when the baby boom generation begins to reach age 65 in 2010. Then the worker/beneficiary ratio is expected to decline to 2.3 in 2030 as the last of the baby boomers reaches age 65. The ratio is expected to continue declining thereafter (but more gradually) as life expectancy continues to lengthen. HI expenditures are projected to grow rapidly as a fraction of workers' earnings, from 3.4 percent in 1997 to about 7.8 percent in 2070.

Since 1966, the Medicare Part A beneficiaries ages 85 and over have increased from 6.2 percent to 11.9 percent of all aged beneficiaries enrolled in HI.



As a fraction of the Gross Domestic Product (GDP) HI expenditures would grow somewhat more slowly, from 1.7 percent in 1998 to about 3.4 percent in 2070. SMI expenditures are expected to continue to grow faster than the economy as a whole. SMI outlays were less than 1 percent of the GDP in 1998 and are projected to grow to about 2.48 percent by 2020.

Disbursements as a Percent of GDP

Calendar Year	HI	SMI	Medicaid	Total
1998	1.69	0.97	2.2	4.82
2000	1.61	1.07	2.3	4.98
2005	1.65	1.35	2.6	5.60
2020	2.22	2.48	3.1	7.80
2070	3.41	3.31	3.6	10.31

Note: SMI as a percent of GDP will grow larger because of the shift of HHA from HI to SMI. Also, Outpatient PPS picks up a larger share of payments in the out years.

HEALTH DATA

HCFA is the largest consumer and maintainer of health data in the world. There are a number of major initiatives underway to move HCFA into the twenty-first century. The most critical of these is planning for the millennium.

Millennium

The millennium initiative is discussed in detail at the beginning of the Initiatives/ Accomplishments Section of the Overview.

Information Systems Security

HCFA's business needs and information technology capabilities are changing the way HCFA is doing business. We have an ever expanding set of partners and customers; we want to conduct business more quickly using direct telecommunications; we have a presence on the Internet and wish to leverage its capabilities in greater ways. This environment presents new opportunities as well as new information systems security risks that HCFA must manage. We recognize that, with HCFA's missions increasingly dependent on information, a strong systems security infrastructure is essential to HCFA's success. In 1998, an effective security infrastructure was outlined and implementation has begun.

Health Data Standards

Health data standards for electronic health care commerce are mandated by HIPAA. The statute requires HCFA, on behalf of HHS, to adopt standards for both data and privacy of health insurance transactions. The first challenge to be faced will be the logistical challenge of analyzing and responding to the high volume of public comments expected on the proposed regulations. More than 24,000 comments were received for the four proposed rules published to date. Since these standards will apply to the entire health care industry, rather than just to Federal programs, these comments represent a wide range of viewpoints. The next challenge is to synthesize these disparate views into final rules that meet the needs of the industry as a whole. Finally, HCFA will be called upon to facilitate the industry's implementation of the standards, and to implement the standards in the Medicare and Medicaid program.

CLAIMS PAYMENT ACCURACY

The OIG reported HCFA's estimated claims payment accuracy in their audit, "Improper Fiscal Year 1998 Medicare Fee-for-Service Payments"(A-17-99-00099). The audit found an estimated payment error of $7.8 to $17.4 billion of the $176.1 billion in processed fee-for-service claims paid by HCFA in FY 1998, with a midpoint of $12.6 billion. The overwhelming

majority of these improper payments were detected through medical record reviews coordinated by the OIG. When these claims were submitted for payment to Medicare contractors, they contained no visible errors. The OIG found an estimated improper error rate of 4.4 to 9.9 percent with a midpoint of 7.1 percent. These errors were identified through this look-behind review of claims by the medical review staff and the PROs. Medicare, like other insurers, makes payments based on a standard claims form. Providers are supposed to retain supporting documentation and make it available upon request. The complete audit is available on the HHS, OIG web site at —http//www.hhs.gov/progorg/oig/.

This was a significant improvement over FY 1997 when estimated improper payments ranged from $12.1 to $28.4 billion. This was about 11 percent of the $177.4 billion in processed fee-for-service claims paid by HCFA in FY 1997. In 1996, the estimated improper Medicare benefits payments were $17.8 to $28.6 billion, or about 14 percent of the $168.6 billion in processed fee-for-service payments.

Most of the errors fell into four general categories: insufficient or no documentation, lack of medical necessity, incorrect coding, and noncovered/unallowable services. The largest observed improvements were in reductions in errors associated with the documentation category, including a substantial reduction in errors associated with situations where providers were under investigation and the OIG previously could not obtain medical records to support billed services.

Our corrective action plan helps us sustain the momentum of these error reductions. We will build on activities begun in prior years to further decrease the error rate, by implementing our comprehensive plan for program integrity. This comprehensive plan includes a focus on improving medical review and benefit integrity, ensuring provider integrity, developing payment safeguards as new programs and payment methods are implemented, implementing contracting authority for the Medicare Integrity Plan, and developing program integrity contingency plans.

Our comprehensive plan includes many activities and action points, including specific activities which will address continuing areas of concern identified by the CFO audit. In particular, we plan to continue our work to refine guidelines for coding of physician services and initiate a strengthened educational campaign to assist physicians in complying with Medicare rules. We plan to initiate heightened review of inpatient hospital claims and of claims for partial hospitalization services.

FINANCIAL REPORTING

Accounts Receivable

The audit of the financial statements focuses on the amounts reported to determine if they are fairly stated and can be supported by subsidiary documentation. The quarterly Contractor Financial Report, Form HCFA-750/751, submitted by the Medicare contractors is one of the primary sources of the amounts shown on the financial statements, and the auditors focus on how these amounts are derived as part of their audit. In 1998, the Medicare accounts receivables showed improvement, however, the 1997 qualification based on a lack of an integrated receivable/accounting system and the failure of some contractors to provide substantiation for the amounts reported was not removed. Due to Y2K concerns, HCFA is working within the existing systems to provide support for the receivables values. The ultimate solution is an integrated accounting system, and we are currently reviewing systems options and working on the requirements of an integrated accounting system so that when the Y2K curtain lifts, we will be ready to move ahead on this initiative.

Debt Collection Improvement Act (DCIA)

Under the DCIA, Federal agencies are required to refer debts to the Treasury Offset Program (TOP) and transfer debts to a Designated Debt Collection Center (DCC) for cross servicing once they have become 180 days delinquent. Debts referred to the TOP are housed in the National Interactive Database and matched to federal payments for potential offset, although agencies continue to pursue collection of these debts unless the statue of limitations has been reached. HCFA is required to discontinue collection activity on debts transferred to a DCC for cross servicing. The DCC performs a variety of collection activities including sending additional demand letters, referring information to credit reporting agencies, skiptracing, referring debts to the TOP, referring debts to private collection agencies, negotiating repayment agreements, and eventually referring debts to the Department of Justice for litigation if necessary. HCFA has actively embraced DCIA and begun the task of validating and referring its delinquent debts to a DCC.

BALANCED BUDGET ACT (BBA) OF 1997

HCFA is charged with implementing a number of changes to the Medicare and Medicaid programs as a result of the BBA. As discussed earlier, some BBA provisions will not be implemented until Y2K compliance is assured.

In addition, the BBA imposes new responsibilities on HCFA to expand and strengthen our partnering activities beyond beneficiary advocacy and support organizations to now include both other government agencies, major employers, unions, professional associations, and foundations with health care agendas.

Medicare+Choice

One of the challenges facing the Medicare+Choice program is to assure that the program is attractive for both beneficiaries and health plans. A number of plans declined to renew their contracts for 1999 or reduced their service areas. These plans cited a number of factors which affected their decision including low payments, additional regulatory requirements imposed by the BBA, local market conditions, and strategic business decisions. On the other hand, more than 300 contracts of the approximately 350 risk contracts in effect at the end of 1998 were renewed for 1999. HCFA will have to balance the requirements imposed on plans to improve quality with the need to assure that beneficiaries have a choice of plans and health insurance options envisioned under the BBA.

As we strive to expand beneficiary choice, we have taken steps to protect Medicare managed care enrollees. We have taken the lead in setting quality standards for managed care through the implementation of HEDIS® for Medicaid and Medicare and through our partnership with the AHCPR, to name a few. We have expedited the Medicare +Choice grievances and appeals process. We also need to expand the new health insurance portability rules to improve access to Medigap insurance plans, and make it possible for beneficiaries to try other health insurance options and return to fee-for-service and Medigap coverage if they decide to do so.

HHA A-B Shift

Section 4611 of the Balanced Budget Act (BBA) redefines the way that home health agency (HHA) benefits are charged to the hospital insurance (HI) and supplementary medical insurance (SMI) trust funds. Beginning January 1998, for beneficiaries entitled to both HI and SMI, the first 100 visits within a spell of illness are charged to HI; and subsequent visits or visits not under a plan of care are charged to SMI. Section 4611(e) of the BBA provides for a six year transition, from 1998 to 2002, to transfer these HHA benefits from the HI trust fund to the SMI trust fund.

Due to systems constraints, this provision was first implemented in July 1998. Computer problems that occurred during implementation cannot be fully corrected until millennium testing is completed. As a result, we do not have reliable data to quantify the expenditures shift from HI to SMI. Subsequent trust fund transfers to implement the six year transition were made using actuarial estimates. This method will continue to be used until actual data are available.

MEDICARE CONTRACTOR OVERSIGHT

Medicare contractors play an important partnership role with HCFA in safeguarding the fiscal integrity of the Medicare trust funds. HCFA assesses and drives improvements to the

effectiveness and quality of contractor performance through Contractor Performance Evaluation (CPE). CPE is designed to afford flexibility in evaluating contractors by allowing the review of any and all activities required of intermediaries and carriers. Performance reviews are conducted primarily by regional office staff.

The FY 1998 CPE program contains core standards that were evaluated at each contractor and reflect HCFA priorities:

- Assess contractor's Y2K compliance;
- Validate selected financial data reported in the HCFA 750/751; and
- Review contractor prepayment medical review and special initiatives related to CFO findings.

In addition, follow-up reviews were conducted of all deficiencies identified through prior year reviews. Where resources permit, regional offices, using risk analysis, identified additional review areas at individual contractors.

The need for reallocation of resources to meet the highest agency priorities (Y2K, BBA, Managed Care growth) has resulted in the need to develop more innovative approaches for doing better evaluation and targeting of those program areas that are most vulnerable to fraud, abuse, and waste. Greater reliance is being placed on the use of performance data indicators to highlight these vulnerabilities. Greater focus is being placed on abuse prone benefits such as home health and durable medical equipment. We continue to review options to determine the most productive approaches.

Financial Statement Highlights

Consolidated Balance Sheet

The Consolidated Balance Sheet presents amounts of future economic benefits owned or managed by HCFA (assets), amounts owed (liabilities), and amounts which comprise the difference (net position). HCFA's Consolidated Balance Sheet shows $181.2 billion in assets. The bulk of these assets are in the Trust Fund Investments of $157.8 billion, which are invested in U.S. Treasury Special Issues, special public obligations for exclusive purchase by the Medicare trust funds. Trust fund holdings not necessary to meet current expenditures are invested in "interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States." The next largest asset is the fund balance

of $16.8 billion, most of which is for Medicaid and CHIP. Liabilities of $40.1 billion consist primarily of the entitlement benefits due and payable of $39.6 billion. HCFA's net position totals $141.1 billion and reflects the cumulative results of the Medicare Trust Fund investments and the unexpended balance for CHIP.

An Anticipated Transfer from SMI of $200 million is shown in the Consolidating Balance Sheet in the Supplementary Section. Section 4732 of the BBA requires the Secretary of HHS to allocate money from the SMI trust fund to the State Medicaid programs for the purpose of paying the SMI premiums for certain additional low-income Medicaid beneficiaries for premiums payable in 1998 through 2002. The allocation for 1998 is limited to $200 million.

Consolidated Statement of Net Cost

The Consolidated Statement of Net Cost shows the cost of the major components of HCFA's operations, less any earned revenues. The three major programs that HCFA administers are Medicare, Medicaid, and CHIP.

Total Benefit Payments were $307.5 billion. This amount includes estimated improper Medicare payments of $7.8 to $17.4 billion based on an audit by the Office of the Inspector General. This is discussed in greater detail in the Challenges Section. Administrative Expenses are $2.9 billion, less than 1 percent of total Program/Activity Costs of $311.8 billion.

The total cost of each of the three major programs; Medicare, Medicaid, and CHIP, is shown on the Total Program/Activity Costs line of the Consolidating Statement of Net Cost in the Supplementary Section. The net cost of the Medicare program including benefit payments, Peer Review Organizations, Medicare Integrity Program spending, and administrative costs, was $258 billion. HI Program/Activity Costs of $142.4 billion were offset by $1.3 billion in premiums. SMI Program/Activity Costs of $136.4 billion includes $59.8 billion from the Payments to the Health Care Trust Fund and were offset by premiums of $19.4 billion.

Medicaid expenses were $97.9 billion. This represents expenses incurred by the States and Territories that were reimbursed by HCFA during the fiscal year, plus accrued payables. CHIP administrative expenses of $3 million are shown. Activity during the year related primarily to getting State plans approved.

Consolidated Statement of Changes in Net Position

The Consolidated Statement of Changes in Net Position shows the net cost of operations less financing sources other than exchange revenues, and the net position at the end of period. The line, Appropriations Used, represents the Medicaid appropriation of $97.9 billion. Medicaid is financed by a general fund appropriation provided by Congress. Employment tax revenue

is Medicare's portion of payroll and self-employment taxes collected under the Federal Insurance Contribution Act (FICA) and Self-Employment Contribution Act (SECA) for the HI Trust Fund totaling $121.9 billion. The Federal matching contribution is income to the SMI program from a general fund appropriation (Payments to the Health Care Trust Funds) of $59.8 billion, that matches monthly premiums paid by beneficiaries.

Combined Statement of Budgetary Resources

The Combined Statement of Budgetary Resources provides information about the availability of budgetary resources as well as their status at the end of the year for each of the budgetary accounts. HCFA had budget authority of $390 billion and unobligated balances of $158 billion. Total budgetary resources were $554.4 billion. Obligations of $388.9 billion leave available unobligated balances of $165 billion. Total outlays were $379.9 billion. Net outlays were $294 billion. The difference is $65 billion in the Payments to the Health Care Trust Funds Appropriation, which is appropriated from the general fund into the SMI trust fund, then expended as benefit payments; and $20 billion relating to the Bureau of Public Debt collection of premiums.

Combined Statement of Financing

The Combined Statement of Financing is a reconciliation of the preceding statements. Obligation-based measures are used in the Combined Statement of Budgetary Resources, while accrual-based measures are used in the other statements, especially in the treatment of liabilities. HCFA's general ledger supports the Report on Budget Execution (SF-133) and the Combined Statement of Budgetary Resources. A liability not covered by budgetary resources may not be recorded as a funded liability in these budgetary accounts. Therefore, these liabilities are recorded as contingent liabilities on the general ledger. Based on appropriation language, they are considered "funded" liabilities for purposes of the Consolidated Balance Sheet, Consolidated Statement of Net Cost and Consolidated Statement of Changes in Net Position. A reconciling item has been entered on the Combined Statement of Financing in the line called accrued entitlement benefit costs.

Discussion of Auditors' Opinion

We have worked closely with the independent auditing firms, Ernst & Young LLP and Clifton Gunderson LLP, to assist them in understanding our very complex programs and the multitude of financial systems used to develop this financial statement. We continue to be hampered because the Medicare contractors do not have integrated accounting systems.

The Medicare and Medicaid programs are decentralized and operated in a partnership with Medicare contractors and States and Territories. This arrangement provides HCFA with operating challenges that are unique within the Federal Government. Medicare and Medicaid claims are paid by 66 contractors and 57 States and Territories, using multiple systems and processes. This compounds the difficulty, complexity, and expense of making systems and operating changes. The systems that have been designed to pay medical providers and suppliers are segmented according to the type of medical service and the locality where it was provided. From the inception of the program, each contractor and State were allowed to have their own payment process and few have a standard general ledger. Over the last few years we have begun standardizing the claims processing systems and standardized interface requirements but each contractor continues to have their own method of operation.

The Medicare program is complex, because we serve beneficiaries, but pay providers. The relationship between the two is difficult to capture through the claims payment systems in a way that the cost can be tracked by beneficiary. For example, when a cost is incurred because a beneficiary receives a medical service, the payment is made to the medical provider. A doctor may bill Medicare biweekly for a group of beneficiaries and receive one check. Data are kept by beneficiary, but payment data may not easily reveal which beneficiaries are included when the payments are made. If an overpayment to a provider is inadvertently made in one payment cycle, it is withheld from the provider check the following payment cycle.

Although program audits find that our systems are doing the job for which they were intended, i.e., ensuring eligibility of beneficiaries and providers, pricing out medical procedures, paying bills correctly, and making adjustment to provider accounts, the systems do not meet CFO Act and Federal Financial Management Improvement Act requirements since most contractors do not have a general ledger. We also have concerns about their readiness for the millennium. The ultimate solution to the financial reporting problem at the Medicare contractors is shared standardized systems, improved oversight of contractor operations, and automation of the financial reporting process. The long term project to standardize contractor systems and incorporate accounting and reporting processes into their design, must yield priority to the Y2K certifications.

The Medicaid process is complicated by the Federal-State relationship. We must ask each State to provide relevant financial reporting that can be included in HCFA's financial statement. States that receive federal funds are subject to a single federal audit.

Accounts Receivables (A/R) Corrective Actions

In 1998, we asked the Medicare contractors to "snapshot" their systems at the end of each quarter to provide more information on receivables and payables for the auditors. (Claims operating systems are updated daily and do not ordinarily have a "history" file.) We also sent

technical teams to Medicare contractors. The teams, consisting of HCFA central and regional staff and personnel from the OIG and GAO, were charged with reviewing systems, reconciling financial data, and ensuring that appropriate audit trails were accessible to the auditors. The cooperation among these agencies and the contractors has led to improved protocols and a sharing of "best practices." In addition, visits were made to a large contractor that left the program to ensure that overpayments were transferred properly. We have come to a clearer understanding of the type of documentation the contractors need to maintain to support the audit.

In 1999, the short term CAP must be focused on non-systems solutions until Y2K is completed. Our corrective actions involve a phased approach. During the early part of FY 1999, we will work with the auditors and with a CPA firm to clarify exactly what documentation is available and necessary to support the A/R. Based on this information we will issue revised financial reporting instructions to clarify receivables reporting policy and to ensure more consistent contractor operations. These instructions will be re-enforced by a training session for all contractors. We will also ask the contractors to conduct a one-time reconciliation of all receivables. This will be bolstered by a clear policy on writeoffs and a one-time adjustment of undocumented receivables.

Our long range plan is to implement an integrated accounting system. The system will include both overpayment tracking and financial reporting and is currently being designed.

Medicare Secondary Payor (MSP) Group Health Plan (GHP) Receivables

The largest single type of debt in HCFA's receivables over 180 days is MSP GHP debt. These debts were generated primarily from the HCFA/IRS/SSA Data Match, and were directed at insurance companies or employers who should have been the primary payor. Over the years, this activity has generated a variety of collection and litigation activity.

We have had difficulty in valuing the dollar amounts shown for MSP GHP receivables. Current discussions indicate that HCFA may have been overstating these receivables by reporting them when legal liability is established rather than at some later point when further information regarding the amount of the debt may be available. We are reviewing our policy on identification of receivables to ensure that MSP GHP debts are booked at the appropriate time from an accounting, as well as a legal, standpoint so that our assets are not overstated.

We have also had difficulty in valuing the dollar amounts shown for the allowance. The Office of General Counsel (OGC) and the Department of Justice (DOJ) negotiated various settlements with insurers for existing and projected GHP debts that were not tied directly to

the GHP accounts receivable. Systems limitations have prevented the settlement amounts from being associated with individual receivables. Consequently, receivables continue to be reported that should have been closed as a result of the settlements.

During 1999, the Mistaken Payment and Recovery Tracking System (MPaRTS) will be updated to enable it to associate receivables with the settlements negotiated with insurers. This information will then be used by HCFA and its contractors to adjust or write-off, as appropriate, receivables linked to these settlements. This project has been delayed because of Y2K efforts. We currently expect to have this project completed in the third quarter of FY 1999.

HCFA is developing a new operational, management, and tracking system for MSP which will be linked to a new Medicare Accounts Receivable System (MARS) that is also under development. This Recovery and Management Accounting System (ReMAS) for MSP will allow HCFA to deal with MSP third party payers (such as insurers or employers) on a national basis rather than on a contractor by contractor basis.

Both ReMAS and MARS will permit the tracking of debts on the basis of joint and several liability, an aspect of MSP recoveries which has been difficult to accomplish with existing systems. ReMAS is in the final requirements stage of development. The design contractor is currently working in conjunction with the requirements contractors to complete the design by December 1999.

Compliance with Laws and Regulations

As discussed previously, initiatives are underway to meet FFMIA compliance by making our systems ready for Y2K and building an integrated financial accounting system. We are also working to improve the claims payment accuracy through provider education and improved detection.

Internal Controls

The most serious internal control finding relates to EDP controls. In 1998, HCFA established a systems security initiative to: 1) aggressively address the known vulnerabilities, and 2) build the capacity to maintain an effective security posture for HCFA's dynamically changing business environment. We recognize Y2K as our most important vulnerability; and therefore have made that our top priority. We have taken several parallel paths to address the EDP controls weaknesses. Where there was a no cost or low cost technical solution, HCFA and its contractors took immediate actions to correct the specific instances of vulnerabilities found through the CFO audit process. Where no technical solutions are readily available, we are introducing administrative control measures as safeguards until a viable technical solution can

be implemented. At the same time, HCFA is developing long term and broad scale solutions using a more methodical IT investment management approach to ensure cost-effectiveness. We are also looking for ways to preserve some of the disciplines introduced by the Y2K re-engineering. One management strategy is to devote more attention to the up-front security testing of new IT solutions. To that end, HCFA has solicited OIG assistance in testing a new network technology solution.

Limitations of the Financial Statements

The financial statements have been prepared to report the financial position and results of operations of HCFA, pursuant to the requirements of 31 U.S.C. 3515(b) and the Chief Financial Officers Act of 1990, (P.L. 101-576).

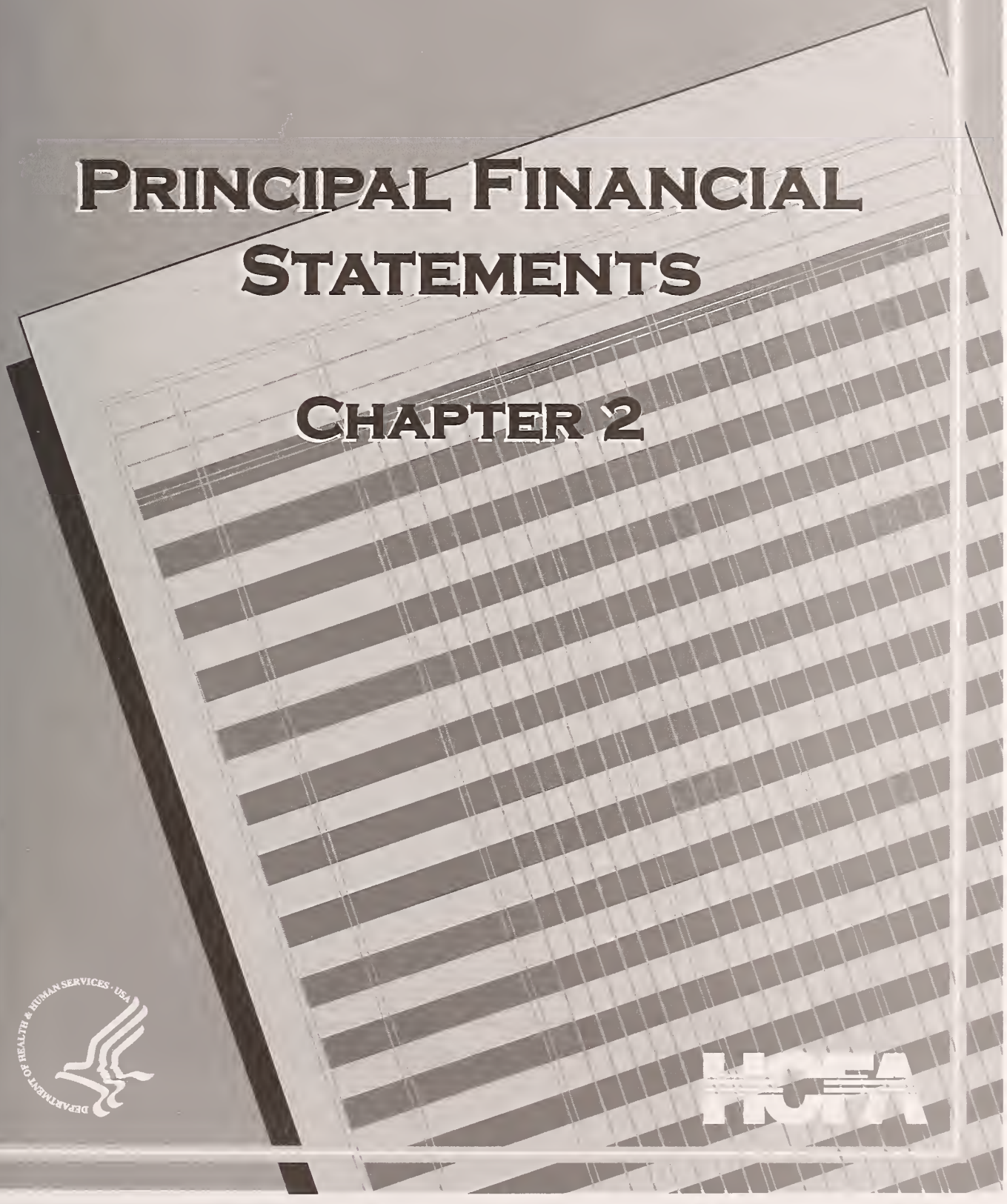
These financial statements have been prepared from HCFA's general ledger and subsidiary reports and supplemented with financial data provided by the U.S. Treasury in accordance with the formats prescribed by the Office of Management and Budget. These statements use accrual accounting, and some amounts shown will differ from those in other financial documents, such as the Budget of the U.S. Government and the annual reports of the Boards of Trustees for HI and SMI, which are presented on a cash basis. The accuracy and propriety of the information contained in the principal financial statements and the quality of internal controls rests with management.

U.S. Department of Health and Human Services

Health Care Financing Administration

Principal Financial Statements

Chapter 2



CONSOLIDATED BALANCE SHEET
As of September 30, 1998 (in millions)

	Consolidated Totals
ASSETS	
Entity Assets:	
Intragovernmental Assets:	
Fund Balances *(Note 2)*	$16,792
Trust Fund Investments *(Note 3)*	157,752
Trust Fund Investment Interest Receivable	2,865
Accounts Receivable, Net	7
Total Intragovernmental Assets	177,416
Accounts Receivable, Net	
Medicare Secondary Payer (MSP) *(Note 4)*	245
Medicare Non-MSP *(Note 5)*	3,327
Other Accounts Receivable	37
Advances and Prepayments	38
Restricted Cash	51
Property and Equipment, Net	25
Total Entity Assets	**181,139**
Non-Entity Assets: Interest and Penalties Receivable, Net	**102**
TOTAL ASSETS	**$181,241**
LIABILITIES	
Liabilities Covered by Budgetary Resources:	
Intragovernmental Liabilities:	
Accounts Payable	$4
Liabilities for Loan Guarantees	3
Uncollected Revenue due Treasury	278
Other Intragovernmental Liabilities	13
Total Intragovernmental Liabilities	298
Accounts Payable	50
Suspense Accounts Deposit Funds	15
Accrued Payroll and Benefits	17
Entitlement Benefits Due and Payable *(Note 6)*	39,570
Other Liabilities	126
Total Liabilities Covered by Budgetary Resources	**40,076**
Liabilities not Covered by Budgetary Resources:	
Intragovernmental Liabilities:	
Accounts Payable	1
Accrued Leave	24
Other Unfunded Liabilities	6
Total Liabilities not Covered by Budgetary Resources	**31**
TOTAL LIABILITIES	**$40,107**
NET POSITION	
Balances:	
Unexpended Appropriations *(Note 7)*	$6,043
Cumulative Results of Operations	135,091
TOTAL NET POSITION	**$141,134**
TOTAL LIABILITIES & NET POSITION	**$181,241**

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF NET COST

Year Ended September 30, 1998 (in millions)

	Consolidated Totals
PROGRAM/ACTIVITY COSTS	
Benefit Payments *(Note 8)*	$307,501
(Includes estimated improper payments of $7.8-17.4 billion)	
Medicare Integrity Program	607
Administrative Expenses	2,875
Bad Debts and Write-offs	730
Depreciation and Amortization	9
Imputed Cost Subsidies	15
CLIA Expenses	
Intragovernmental	33
With the Public	36
Millennium (Y2K) Costs	30
Miscellaneous Expenses	2
Total Program/Activity Costs *(Note 9)*	**311,838**
Less: Earned Revenues	
Premiums Collected *(Note 10)*	20,747
Medicare + Choice	95
CLIA User Fees Collected	45
Intragovernmental	3
With the Public	2
Total Earned Revenues	**20,892**
NET COST OF OPERATIONS	**$290,946**

CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION

Year Ended September 30, 1998 (in millions)

	Consolidated Totals
Net Cost of Operations	**$290,946**
Financing Sources (other than exchange revenues):	
Appropriations Used	97,870
Employment Tax Revenue *(Note 11)*	121,915
Federal Matching Contribution *(Note 10)*	59,775
Interest on Trust Fund Investments	11,775
Trust Fund Draws	1,631
Revenue Transferred to Program Management	(1,631)
Imputed Financing	16
Millennium (Y2K) Financing	30
Other Revenues and Financing Sources *(Note 12)*	5,816
Total Financing Sources	**297,197**
Net Results of Operations	**6,251**
Prior Period Adjustments *(Note 13)*	(8)
Net Change in Cumulative Results of Operations	**6,243**
Increase in Unexpended Appropriations *(Note 14)*	5,843
Change in Net Position	**12,086**
Net Position-Beginning of Period	129,048
Net Position-End of Period	**$141,134**

The accompanying notes are an integral part of these statements.

COMBINED STATEMENT OF BUDGETARY RESOURCES

Year Ended September 30, 1998 (in millions)	**Combined Totals**
Budgetary Resources:	
Budget authority	$390,279
Unobligated balances - beginning of period *(Note 15)*	157,926
Net transfers prior year balance, actual	(1)
Spending authority from offsetting collections	2,090
Adjustments	4,063
Total Budgetary Resources	**$554,357**
Status of Budgetary Resources:	
Obligations incurred *(Note 15)*	388,941
Unobligated balances - available *(Note 15)*	165,252
Unobligated balances - not available	164
Total Status of Budgetary Resources	**$554,357**
Outlays:	
Obligations incurred *(Note 15)*	388,941
Less: spending authority from offsetting collections and adjustments	(6,218)
Obligated balance, net - beginning of period	7,338
Obligated balance transferred, net	(301)
Less: obligated balance, net- end of period *(Note 15)*	(9,817)
Total Outlays	**$379,943**

The accompanying notes are an integral part of these statements.

COMBINED STATEMENT OF FINANCING
Year Ended September 30, 1998 (in millions)

	Combined Totals
RESOURCES USED TO FINANCE ACTIVITIES	
Budgetary	
Budgetary resources obligated for orders, delivery of goods and services to be received, or benefits to be provided to others	$388,941
Less: offsetting collections, and recoveries of prior-year authority	(6,139)
Net Budgetary Resources Used to Finance Activities	**382,802**
Non-budgetary	
Property received from others without reimbursement	1,831
Property given to others without reimbursement	(1,631)
Costs incurred by others for the entity without reimbursement	16
Net Non-budgetary Resources Used to Finance Activities	**$216**
Total Resources Used to Finance Activities	**$383,018**
RELATIONSHIP of TOTAL RESOURCES to the NET COST of OPERATIONS:	
Budgetary resources that fund expenses recognized in prior periods	41,562
Increase in budgetary resources obligated to order goods and services not yet received or benefits not yet provided.	3,966
Adjustments other than collections made to compute net budgetary resources that do not affect net cost of operations	
Recoveries of prior-year authority	(218)
Resources that do not affect net cost of operations	(764)
Resources that finance the acquisition of assets or liquidation of liabilities	(14)
Total Resources Used to Fund Items Not Part of the Net Cost of Operations	44,532
Resources Used to Finance the Net Cost of Operations	**$338,486**
COMPONENTS NOT REQUIRING OR GENERATING RESOURCES	
Expenses or exchange revenue related to the disposition of assets or liabilities, or allocation of their costs over time:	
Expenses related to use of assets	652
Losses from re-evaluation of assets and liabilities	1
Increase in exchange revenue receivable from the public	(1,809)
Increase in Restricted Cash	(6)
Trust Fund Premiums collected	(20,747)
Other	(24)
Expenses that will be financed with budgetary resources recognized in future periods:	
Accrued Entitlement Benefit Costs	39,570
Other	1
Reversal of FY 1997 accrued Federal Matching Contribution Liability	(144)
Total Components Not Requiring or Generating Resources	**$17,494**
NET COST OF OPERATIONS	**$355,980**

The accompanying notes are an integral part of these statements.

NOTE 1: Summary of Significant Accounting Policies

Reporting Entity

The Health Care Financing Administration (HCFA) is a separate financial reporting entity of the Department of Health and Human Services (HHS). The financial statements have been prepared to report the financial position and results of operations of HCFA, as required by the Chief Financial Officers Act of 1990. The statements were prepared from HCFA's accounting records in accordance with the form and content specified by the Office of Management and Budget (OMB) in OMB Bulletin 97-01.

The financial statements cover all the programs administered by HCFA. The programs administered by HCFA are shown in two categories, Medicare and Health. The Medicare programs include:

Medicare Hospital Insurance (HI) Trust Fund

Medicare contractors are paid by HCFA to process Medicare claims for hospital inpatient services, hospice, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the HI Trust Fund. The financial statements include HI Trust Fund activities administered by the Department of the Treasury (Treasury).

Medicare Supplementary Medical Insurance (SMI) Trust Fund

Medicare contractors are paid by HCFA to process Medicare claims for physicians, medical suppliers, hospital outpatient services and rehabilitation, end stage renal disease (ESRD), rural health clinics, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the SMI Trust Fund. The financial statements include SMI Trust Fund activities administered by Treasury.

Medicare Integrity Program (MIP)

The Health Insurance Portability and Accountability Act, Public Law 104-191, established the MIP, codifying the program integrity activities previously known as "payment safeguards." This account is also called the Health Care Fraud and Abuse Control (HCFAC) Program, or simply "Fraud and Abuse." The MIP contracts with

eligible entities to perform such activities as medical and utilization reviews, fraud reviews, cost report audits, and the education of providers and beneficiaries with respect to payment integrity and benefit quality assurance issues. The MIP is funded by the HI Trust Fund.

Payments to the Health Care Trust Funds Appropriation

The Social Security Act provides for payments to the HI and SMI Trust Funds for SMI (appropriated funds to provide for Federal matching of SMI premium collections) and HI (for the Uninsured and Federal Uninsured Payments). In addition, funds are provided by this appropriation to cover the Medicaid program's share of HCFA's administrative costs. To prevent duplicative reporting, the revenue and expenses of this appropriation are reported only in the Medicare HI and SMI columns of the financial statements.

The Health programs include:

Medicaid

Medicaid, the health care program for low-income Americans, is administered by HCFA in partnership with the States. It is funded by the Grants to the States Appropriation. Grant awards limit the funds that can be drawn by the States to cover current expenses. The grant awards, prepared at the beginning of each quarter and amended as necessary, are an estimate of HCFA's share of States' Medicaid costs. At the end of each quarter, States submit a report of their expenses (net of recoveries) for the quarter, and subsequent grant awards are issued by HCFA for the difference between approved expenses reported for the period and the grant awards previously issued.

The Children's Health Insurance Program (CHIP)

CHIP, included in the Balanced Budget Act of 1997 (BBA), was designed to provide health insurance for children, many of whom come from working families with incomes too high to qualify for Medicaid, but too low to afford private health insurance. The BBA set aside funds for ten years to provide this new insurance coverage. In addition, States may choose to expand CHIP with Medicaid funds. The grant awards, prepared at the beginning of each quarter and amended as necessary, are based on a State approved plan to implement CHIP. At the end of each quarter, States submit a report of their expenses (net of recoveries) for the quarter, and subsequent grant awards are issued by HCFA for the difference between approved expenses reported for the period and the grant awards previously issued.

Health Maintenance Organization (HMO) Loan and Loan Guarantee Fund

The HMO Loan and Loan Guarantee Fund was originally established to provide working capital to HMOs during their initial period of operations and to guarantee loans made by private lenders to HMOs. The last loan commitments were made in FY 1983. Direct loans to HMOs were sold, with a guarantee, to the Federal Financing Bank (FFB). The FFB purchase proceeds were then used as capital for additional direct loans. Therefore, the fund operates as a revolving fund. Currently, HCFA collects principal and interest payments from HMO borrowers, and, in turn, pays the FFB.

Program Management User Fees: Medicare + Choice, Clinical Laboratory Improvement Program, and Other User Fees

This account operates as a revolving fund without fiscal year restriction. The BBA established the Medicare + Choice program. Medicare + Choice plans must make payments for their share of the estimated costs related to enrollment and dissemination of information and certain counseling and assistance programs. These user fees are devoted to educational efforts for beneficiaries and outreach partners. The Clinical Laboratory Improvement Amendments of 1988 (CLIA) marked the first comprehensive effort by the Federal government to regulate medical laboratory testing. HCFA and the Public Health Service share responsibility for the CLIA program, with HCFA having the lead responsibility for financial management. Fees for registration, certificates, and compliance determination of all U.S. clinical laboratories are collected to finance the program. Other user fees are charged for certification of some nursing facilities and for sale of the data on nursing facilities surveys. Proceeds from the sale of data from the public use files and publications under the Freedom of Information Act (FOIA) are also credited to this fund.

Program Management Appropriation

The Program Management Appropriation provides HCFA with the major source of administrative funds to manage the Medicare and Medicaid programs. The funds for this activity are provided from the HI and SMI Trust Funds, the general fund, and reimbursable activities. The Payments to the Health Care Trust Funds Appropriation reimburses the Medicare HI Trust Fund to cover the Medicaid program's share of HCFA's administrative costs (see Note 9). User fees collected from HMOs seeking Federal qualification and funds received from other federal agencies to reimburse HCFA for services performed for them are credited to the Program Management Appropriation.

The cost related to the Program Management Appropriation is allocated among all programs based on HCFA's cost allocation system. It is reported in the Medicare and Health columns of the Consolidating Statements of Net Cost in the Supplementary Section.

Basis of Presentation

The financial statements have been prepared to report the financial position and results of operations of HCFA, pursuant to the requirements of 31 U.S.C. 3515(b), the Chief Financial Officers Act of 1990 (P.L. 101-576), and amended by the Government Management Reform Act of 1994.

These financial statements have been prepared from HCFA's general ledger and subsidiary reports and were supplemented with financial data provided by Treasury in accordance with the formats prescribed by the OMB Bulletin 97-01. Some amounts shown will differ from those in other financial documents, such as the Budget of the U.S. Government and the annual reports of the Boards of Trustees for HI and SMI, which are presented on a cash basis.

Basis of Accounting

HCFA uses the Government's Standard General Ledger account structure and follows accounting policies and guidelines issued by HHS. While the statements are on an accrual basis, transactions are recorded using both the accrual and cash basis of accounting, and a budgetary basis of accounting. Under the accrual method, expenses are recognized when resources are consumed, without regard to the payment of cash. Under the cash method and the budgetary method, expenses are recognized when cash is outlayed. Budgetary accounting facilitates compliance with legal constraints and controls over the use of Federal funds.

HCFA uses the cash basis of accounting in the Medicare program to record benefit payments disbursed during the fiscal year, supplemented by the accrual method to estimate the value of benefit payments incurred but not yet paid as of the fiscal year end. Revenues are also recognized both when earned (without regard to receipt of cash) and, in the case of HI and SMI premiums, when collected. Employment taxes earmarked for the Medicare program are recorded on a cash basis.

HCFA uses the cash basis of accounting in the Medicaid program to record funds paid to the States during the fiscal year, supplemented by the accrual method to estimate the value of expenses (net of recoveries) not yet reported to HCFA as of the end of the fiscal year.

Consolidated Balance Sheet

The consolidated balance sheet presents amounts of future economic benefits owned or managed by HCFA (assets), amounts owed (liabilities), and amounts which comprise the difference (net position). The major components are described below.

Assets include entity assets, which are assets that HCFA holds and has the authority to use in its operations; and non-entity assets, which are assets that HCFA holds but does not have the authority to use. An example of non-entity assets are civil monetary penalties (CMP) receivables, which HCFA collects for the U.S. Government but does not have authority to spend.

Fund Balances are funds with Treasury that are primarily available to pay current liabilities. Cash receipts and disbursements are processed by Treasury. HCFA also maintains lockboxes at commercial banks for the deposit of SMI premiums from States and third parties and for collections from HMO plans.

Trust Fund Investments and Interest Receivable are investments and accrued interest on investments held by Treasury. Sections 1817 for HI and 1841 for SMI of the Social Security Act require that trust fund investments not necessary to meet current expenditures be invested in "interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States." These investments are carried at face value as determined by Treasury. Interest income is compounded semiannually (June and December) and has been adjusted to include an accrual for interest earned from July 1 to September 30.

Medicare Secondary Payer (MSP) Accounts Receivable (A/R), Net consists of amounts owed to Medicare by insurance companies, employers, beneficiaries, and/or providers for payments made by Medicare that should have been paid by the primary payer. MSP A/R represent entity receivables. Receipts are transferred to the HI or SMI Trust Fund upon collection. Amounts due are presented net of an allowance for uncollectible accounts. The allowance for uncollectible accounts is based on past collection experience and/or an analysis of the outstanding balances.

Medicare Non-MSP A/R, Net consists of amounts owed to Medicare by medical providers and others because Medicare made payments that were not due based on cost report settlements. Non-MSP A/R represent entity receivables and, once collected, are transferred to the HI or SMI Trust Fund. Amounts due are presented net of an allowance for uncollectible accounts.

The allowance for uncollectible accounts is based on past collection experience and/or an analysis of the outstanding balances.

Advances and Prepayments are used to report advance payments made to health care providers. These occur when there are billing or claims processing problems and health providers ask for accelerated Medicare payments to minimize problems related to cash flow.

Restricted Cash is the total amount of time account balances at the Medicare contractors' commercial banks. The Checks Paid Letter-of-Credit method is used for reimbursing Medicare contractors for the payment of covered Medicare services. Medicare contractors issue checks against a Medicare Benefits account maintained at commercial banks. In order to compensate commercial banks for handling the Medicare Benefits accounts, Medicare funds are deposited into non-interest-bearing time accounts. The earnings allowances on the time accounts are used to reimburse the commercial banks.

Property and Equipment (P&E) are recorded at full cost of purchase, including all costs incurred to bring the P&E to a form and location suitable for its intended use, net of accumulated depreciation. All P&E with an initial acquisition cost of $25,000 or more and an estimated useful life of 2 years or greater is capitalized. P&E is depreciated on a straight-line basis over the estimated useful life of the asset. Normal maintenance and repair costs are expensed as incurred.

Liabilities represent amounts owed by HCFA as the result of transactions that have occurred. In accordance with Public Law and existing Federal accounting standards, no liability is recorded for any future payment to be made on behalf of current workers contributing to the Medicare Hospital Insurance (HI) Trust Fund.

Liabilities funded by available budgetary resources include: (1) new budget authority, (2) spending authority from offsetting collections, (3) recoveries of unexpired budget authority, (4) unobligated balances of budgetary resources at the beginning of the year, and (5) permanent indefinite appropriation or borrowing authority.

Liabilities not covered by budgetary resources are incurred when funding has not yet been made available through Congressional appropriations or current earnings. HCFA recognizes such liabilities for employee annual leave earned but not taken, and amounts billed by the Department of Labor for Federal Employee's Compensation Act (disability) payments. For HCFA revolving funds, all liabilities are funded as they occur.

Uncollected Revenue due Treasury includes premiums, civil monetary penalties, and interest on Medicare receivables.

Accounts Payable consists of amounts due for goods and services received, progress in contract performance, interest due on accounts payable, and other miscellaneous payables such as worker's compensation (FECA) payments due to the Department of Labor.

Suspense Accounts Deposit Funds are unidentified collections that are deposited into a suspense account for immediate investment by Treasury while HCFA researches the actual application of funds. Agencies are required to deposit receipts expeditiously.

Entitlement Benefits Due and Payable represent Medicare or Medicaid medical services incurred but not paid as of September 30. The Medicare estimate is developed by the Office of the Actuary (OACT) and is based on historical trends of completeness that take into consideration estimated deductible and coinsurance amounts. The estimate represents (1) claims incurred that may or may not have been submitted to the Medicare contractors and were not yet approved for payment, (2) claims that have been approved for payment by the Medicare contractors for which checks have not yet been issued, (3) checks that have been issued by the Medicare contractors in payment of a claim and that have not yet been cashed by payees, (4) periodic interim payments, and (5) retroactive settlements of cost reports.

The Medicaid amount reported is the net of unreported expenses incurred by the States less amounts owed to the States for overpayment of Medicaid funds to providers, anticipated rebates from drug manufacturers, and settlements of probate and fraud and abuse cases. This information was provided by the States.

Other Unfunded Liabilities are the retirement plans utilized by HCFA employees; the Civil Service Retirement System (CSRS) or the Federal Employees Retirement System (FERS). Under CSRS, HCFA makes matching contributions equal to 7 percent of pay. HCFA does not report CSRS assets, accumulated plan benefits, or unfunded liabilities, if any, applicable to its employees. Reporting such amounts is the responsibility of the Office of Personnel Management (OPM).

Most employees hired after December 31, 1983 are automatically covered by FERS. A primary feature of FERS is that it offers a savings plan to which

HCFA is required to contribute 1 percent of pay and to match employee contributions up to an additional 4 percent of pay. For employees covered by FERS, HCFA also contributes the employer's matching share of Social Security taxes.

Net Position contains the following components:

Unexpended Appropriations include the portion of HCFA's appropriations represented by undelivered orders and unobligated balances.

Cumulative Results of Operations represent the net results of operations since the inception of the program plus the cumulative amount of prior period adjustments.

Consolidated Statement of Net Cost

The Consolidated Statement of Net Cost shows the components of the net cost of HCFA's operations for the period by program. Under the Government Performance and Results Act (GPRA) Programs, HCFA is required to identify the mission of the agency and develop a strategic plan and performance measures to show that desired outcomes are being met. The three major programs that HCFA administers are: Medicare, Medicaid, and CHIP. The bulk of HCFA's expenses are allocated to these programs. MIP is included in Medicare. The costs related to the Program Management Appropriation are cost allocated to all three major components.

Program/Activity Costs represent the gross costs or expenses incurred by HCFA for all activities.

Benefit Payments are the payments by Medicare contractors and Medicaid State agencies to health care providers for their services.

Administrative Expenses represent the costs of doing business by HCFA and its partners.

Earned Revenues or exchange revenues arise when a Government entity provides goods and services to the public or to another Government entity for a fee.

Premiums Collected are used to finance SMI benefits and administrative expenses. Monthly premiums paid by Medicare beneficiaries are matched by the Federal government through the general fund appropriation, Payments to

the Health Care Trust Funds. Section 1844 of the Social Security Act authorizes appropriated funds to match SMI premiums collected, and outlines the ratio for the match as well as the method to make the trust funds whole if insufficient funds are available in the appropriation to match all premiums received in the fiscal year.

Net Cost of Operations is the difference between the program's gross costs and its related exchange revenues.

Consolidated Statement of Changes in Net Position

The Consolidated Statement of Changes in Net Position shows the net cost of operations less financing sources other than exchange revenues, and the net position at the end of period. Major components are described below.

Financing Sources (Other than Exchange Revenues) arise primarily from exercise of the Government's power to demand payments from the public (e.g., taxes, duties, fines, and penalties). These include appropriations used, transfers of assets from other Government entities, donations, and imputed financing.

Appropriations Used and Federal Matching Contributions are described in the Medicare Premiums section above. For financial statement purposes, appropriations used are recognized as a financing source as expenses are incurred. A transfer of general funds to the HI Trust Fund in an amount equal to Self-Employment Contribution Act (SECA) tax credits is made through the Payments to the Health Care Trust Funds Appropriation. The Social Security Amendments of 1983 provided credits against the HI taxes imposed by the SECA on the self-employed for calendar years 1984 through 1989.

Employment Tax Revenue is the primary source of financing for Medicare's HI program. Medicare's portion of payroll and self-employment taxes is collected under the Federal Insurance Contribution Act (FICA) and Self-Employment Contribution Act (SECA). Employees and employers were both required to contribute 1.45 percent of earnings, with no limitation, to the HI Trust Fund. Self-employed individuals contributed the full 2.9 percent of their net income.

Combined Statement of Budgetary Resources

The Combined Statement of Budgetary Resources provides information about the availability of budgetary resources as well as their status at the end of the year. Budgetary Statements were developed for each of the budgetary accounts. In this statement, the Program Management and the Program Management User Fee accounts are combined and are not allocated back to the other programs. Also, there are no intra-HCFA eliminations in this statement.

Unobligated Balances - beginning of period represent funds available. These funds are primarily positive trust fund balances.

Budget Authority represents the funds available through appropriations, direct spending authority, obligations limitations, unobligated balances at the beginning of the period or transferred in during the period, spending authority from offsetting collections, and any adjustments to budgetary authority.

Obligations Incurred consists of expended authority, recoveries of prior year obligations and the change in undelivered orders.

Combined Statement of Financing

The Combined Statement of Financing is a reconciliation of the preceding statements. Accrual-based measures used in the Consolidated Statement of Net Cost differ from the obligation-based measures used in the Combined Statement of Budgetary Resources, especially in the treatment of liabilities. A liability not covered by budgetary resources may not be recorded as a funded liability in the budgetary accounts of HCFA's general ledger, which supports the Report on Budget Execution (SF-133) and the Combined Statement of Budgetary Resources. Therefore, these liabilities are recorded as contingent liabilities on the general ledger. Based on appropriation language, they are considered "funded" liabilities for purposes of the Consolidated Balance Sheet, Consolidated Statement of Net Cost and Consolidated Statement of Changes in Net Position. A reconciling item has been entered on the Combined Statement of Financing.

Use of Estimates in Preparing Financial Statements

Preparation of financial statements in accordance with federal accounting standards requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial

statements and the reported amounts of revenues and expenses during the reporting period. Actual results may differ from those estimates.

Intra-Governmental Relationships and Transactions

In the course of its operations, HHS has relationships and financial transactions with numerous Federal agencies. HHS interacts with the Social Security Administration (SSA) and Treasury. SSA determines eligibility for Medicare programs, and also allocates a portion of Social Security benefit payments to the Medicare Part B Trust Fund for Social Security beneficiaries who elect to enroll in the Medicare Part B program. The Treasury receives the cumulative excess of Medicare receipts and other financing sources, and issues interest-bearing securities in exchange for the use of those monies. At the Government-wide level, the assets related to the trust funds on HHS financial statements and the corresponding liabilities on the Treasury's financial statements should be eliminated.

Accounting Changes

The following accounting changes were made in the 1998 financial statements:

Invested Capital and Future Funding Requirements are no longer shown. These categories were closed out with a prior period adjustment in accordance with OMB Circular 97-01.

A liability not covered by budgetary resources may not be recorded as a funded liability in the budgetary accounts of our general ledger, which supports the Report on Budget Execution (SF-133), and the Combined Statement of Budgetary Resources. Because our general ledger must meet budgetary requirements, we have recorded these as contingent liabilities on our general ledger and as "funded" liabilities on the Consolidated Balance Sheet. A reconciling item has been entered on the Combined Statement of Financing. This policy change for fiscal year (FY) 1998 was mandated by OMB.

Prior to FY 1998, activity relating to the Payments to the Health Care Trust Funds Appropriation was reported under the "All Others" column. For FY 1998, activity relating to this appropriation has been reported under HI and SMI. Accordingly, the FY 1998 Net Position-Beginning Balance of HI reflects an increase of $26 million, which represents the Payments to the Health Care Trust Funds Net Position-Beginning Balance attributable to HI. There was no amount attributable to SMI.

Comparative Data

OMB Bulletin 97-01, "Form and Content of Agency Financial Statements" provides that comparative financial statements are permitted but not required until reporting periods beginning after September 30, 1999 (FY 2000). Management has determined that, due to the implementation of new Federal Accounting Standards Advisory Board accounting standards and five new principal financial statements for FY 1998, it is not feasible nor prudent to attempt to restate FY 97 amounts in the current statements. Therefore, comparative financial statements are not presented.

Estimation of Obligations Related to Canceled Appropriations

As of September 30, 1998, HCFA has canceled over $82 million in cumulative obligations to FY 1993 and prior years in accordance with the National Defense Authorization Act of Fiscal Year 1991 (P.L. 101-150). Based on the payments made in FY 1994 through 1998 related to canceled appropriations, HCFA anticipates an additional $2.5 million will be paid from current year funds for canceled obligations.

NOTE 2: Fund Balances (Dollars in Millions)

	Obligated	Unobligated Available	Unobligated Restricted	Consolidated Total
Trust Funds				
HI Trust Fund Balance *(1)*	$(1,341)		$29	$(1,312)
SMI Trust Fund Balance *(1)*	1,391		820	2,211
Revolving Funds				
HMO Loan *(2)*		$11		11
CLIA *(2)*	96	13		109
Appropriated Funds				
Medicaid	10,750	766		11,516
CHIP	3,745	485		4,230
Other Fund Types				
HCFA Suspense Account *(2)*		14		14
Program Management Reimbursables *(2)*		13		13
Total Entity Fund Balances	**$14,641**	**$1,302**	**$849**	**$16,792**

(1) The restricted portions of the HI and SMI fund balances represent the remaining fund balance in the Payments to the Health Care Trust Funds appropriation, which is allocated to HI and SMI.

(2) These fund balances are reported in the Supplementary Information section under the "All Others" column of the Consolidating Balance Sheet.

NOTE 3: Trust Fund Investments (Dollars in Millions)

	Maturity Range	Interest Range	Face Value
HI Investments			
Certificates	June 1999	5 3/8%	$2,447
Bonds	June 1999 to June 2012	5 7/8 - 13 3/4%	115,803
Total HI Investments			118,250
SMI Investments			
Certificates	June 1999	5 3/8 - 5 3/4%	3,426
Bonds	June 1999 to June 2013	5 7/8 - 8 3/4%	36,076
Total SMI Investments			39,502
Total Medicare Investments			**$157,752**

U.S. Treasury Special Issues are special public obligations for exclusive purchase by the Medicare trust funds. Special issues are always purchased and redeemed at face value. The face value less amounts retired to fund Medicare program expenses by the programs is the net amount outstanding reported in the Consolidated Balance Sheet. This schedule summarizes the nature and amount of investments in the Medicare trust funds.

Note 4: Medicare Secondary Payer (MSP) (Dollars in Millions)

	Medicare		
	HI	**SMI**	**Total**
Accounts Receivable Principal	$1,085	$737	$1,822
Less: Allowance for Uncollectible Accounts	(939)	(638)	(1,577)
Total MSP Accounts Receivable, Net	**$146**	**$99**	**$245**

MSP receivables are composed of paid claims in which Medicare should have been the secondary rather than the primary payer. Claims that have been identified to a primary payer are included in the MSP receivable amount. An additional 1.5 million claims that are being researched as potential MSP receivables have not been reported due to the uncertain nature of the leads. The allowance for uncollectible accounts is derived from data based on the last five years of collection experience.

The largest single type of debt included in MSP receivables is MSP group health plan (GHP) debt. These debts were generated primarily from the HCFA/IRS/SSA Data Match, and were directed at insurance companies or employers who should have been the primary payer.

Current discussions indicate that HCFA may have been overstating the GHP portion of the MSP receivables by reporting them when legal liability is established rather than at some later point when further information regarding the amount of the debt may be available. We are reviewing our policy on identification of receivables to ensure that these debts are booked at the appropriate time from both an accounting standpoint as well as a legal standpoint so that our assets are not overstated.

The dollar amounts shown for the allowance for uncollectible accounts are also open to question. The Office of General Counsel (OGC) and the Department of Justice (DOJ) negotiated various settlements with insurers for existing and projected GHP debt that were not tied directly to receivable records. Systems limitations have prevented the settlement amounts from being associated to the individual records resulting in overstating amounts reported for receivables and the allowance for uncollectible accounts.

Note 5: Medicare Non-MSP (Dollars in Millions)

	Medicare		
	HI	**SMI**	**Total**
Provider & Beneficiary Overpayments			
Accounts Receivable Principal	$3,602	$1,269	$4,871
Less: Allowance for Uncollectible Accounts	(1,419)	(630)	(2,049)
Accounts Receivable, Net	2,183	639	2,822
CMPs & Other Restitutions			
Accounts Receivable Principal	60	178	238
Less: Allowance for Uncollectible Accounts	(30)	(8)	(38)
Accounts Receivable, Net	30	170	200
Fraud and Abuse			
Accounts Receivable Principal	8	88	96
Less: Allowance for Uncollectible Accounts	(7)	(86)	(93)
Accounts Receivable, Net	1	2	3
Managed Care			
Accounts Receivable Principal	3	8	11
Less: Allowance for Uncollectible Accounts	0	(5)	(5)
Accounts Receivable, Net	3	3	6
Medicare Premiums			
Accounts Receivable Principal	109	222	331
Less: Allowance for Uncollectible Accounts	(19)	(25)	(44)
Accounts Receivable, Net	90	197	287
Audit Disallowances			
Accounts Receivable Principal	2	7	9
Less: Allowance for Uncollectible Accounts	—	—	—
Accounts Receivable, Net	2	7	9
Total Non-MSP Accounts Receivable Principal	3,784	1,772	5,556
Less: Allowance for Uncollectible Accounts	(1,475)	(754)	(2,229)
Total Non-MSP Accounts Receivable, Net	**$2,309**	**$1,018**	**$3,327**

Accounts receivable data were primarily obtained from data provided by the Medicare contractors. These receivables are composed of provider and beneficiary overpayments. The allowance for uncollectible accounts is derived from data based on the last five years of collection experience by type of receivable.

Note 6: Entitlement Benefits Due and Payable (Dollars in Millions)

	Medicare					Consolidated
	HI	SMI	Total	Medicaid	Others	Total
Medicare Benefits Payable *(1)*	$17,757	$10,978	$28,735			$28,735
Demonstrations and HMO Benefits	35	17	52			52
Medicare Integrity Program	3		3			3
Medicaid Benefits Payable *(2)*				$10,664		10,664
Medicaid Audit/Program Disallowances *(3)*				116		116
Total	**$17,795**	**$10,995**	**$28,790**	**$10,780**		**$39,570**

(1) Medicare benefits payable consists of (1) $28.7 billion estimate by HCFA's actuary of Medicare services incurred but not paid, as of September 30, 1998, plus (2) $30 million anticipated payout for a court case.

(2) Medicaid benefits payable of $10.7 billion is an estimate of the net Federal share of expenses that have been incurred by the States but not yet reported to HCFA as of September 30, 1998.

(3) Medicaid audit and program disallowances of $116 million are contingent liabilities that have been established as a result of Medicaid audit and program disallowances that are currently being appealed by the States. In all cases, the funds have been returned to HCFA. HCFA will be required to pay these amounts if the appeals are decided in the favor of the States. In addition, certain amounts for payment have been deferred under the Medicaid program when there is a reasonable doubt as to the legitimacy of expenditures claimed by a State. HCFA defers the payment of these claims until the State provides additional supporting data. Based on historical data, HCFA expects to eventually pay approximately 31.4 percent of total contingent liabilities. Therefore, of the total contingent liabilities of $369 million, HCFA expects to pay approximately $116 million.

Appeals at the Office of Hearings

Other liabilities do not include all provider cost reports under appeal at the Office of Hearings (OH). The monetary effect of those appeals is generally not known until a decision is rendered. As of September 30, 1997, there were 9,796 cases under appeal at the OH. A total of 3,612 new cases were filed in FY 1998. The OH rendered decisions on 108 cases in FY 1998 and 3,373 additional cases were dismissed, withdrawn or settled prior to an appeal

hearing. The Office gets no information on the value of these cases that are settled prior to a hearing. Since data is available for only the 108 cases that were decided in FY 1998, a reasonable liability estimate cannot be projected for the value of the 9,927 cases remaining on appeal as of September 30, 1998. As cases are decided, the settlement value paid is considered in the development of the actuarial liability estimate.

Note 7: Unexpended Appropriations (Dollars in Millions)

	Medicare						Consolidated
	HI	SMI	Total	Medicaid	CHIP	Others	Total
Unobligated							
Available					$485	$24	$509
Unavailable	$15	$789	$804	$764			1,568
Undelivered Orders				200	3,750	16	3,966
Total Unexpended Appropriations	**$15**	**$789**	**$804**	**$964**	**$4,235**	**$40**	**$6,043**

Note 8: Medicare Benefit Payments

Medicare Claims Estimated Improper Payments

Federal government audits require the review of programs for compliance with Federal laws and regulations. Accordingly, the OIG reviewed a statistically valid sample of Medicare claims to determine that claims were paid properly by Medicare contractors, and that services were actually performed and were medically necessary. Medicare, like other insurers, makes payments based on a standard claims form. The internal claims process involves reviewing claims as billed and paying the correct amount for the services rendered. The claims submitted for payment to Medicare contractors contained no visible errors. However, when the medical review asked for documentation from providers to support their claims, there was an 7.1 percent error rate with a dollar value in the range of $7.8-$17.4 billion ($12.6 billion midpoint). The majority of the errors fell into four broad categories: lack of medical necessity, insufficient or no documentation, incorrect coding, and noncovered/unallowable services.

Cost Report Settlement Process

The cost report settlement process represents the value of final outlays to providers based on fiscal intermediary (FI) audits, reviews and final settlements of Medicare cost reports. All institutional providers are required to file Medicare cost reports. For providers paid under the prospective payment system (PPS), the cost report includes costs that are not covered under PPS, such as disproportionate share hospital payments, indirect medical education payments, and other indirect costs. For providers paid on a cost basis, the cost report represents the total costs incurred by the provider for medical services to patients and reflects the final distribution of these costs to the Medicare program.

In 1998, 32,903 cost reports totaling $95.9 billion were reviewed. Approximately $70 billion represented inpatient claims to PPS providers. These inpatient claims were included in prior years' claims testing that resulted in the determination of the Medicare claims improper payment error rate. The cost report settlements, therefore, focused on the remaining non-PPS balance of about $26 billion.

1998 Cost Report Summary
(Dollars in millions)

	Desk Reviews and Other	Audits	Total
Providers	27,101	5,802	32,903
Costs Claimed	$36,119	$59,781	$95,900
Disallowed	$552	$1,083	$1,635

The $1.6 billion disallowed represents 6 percent of the $26 billion non-PPS balance. Based on the current disallowance rates, if the full-scope audits were expanded to include the entire universe, the total amount disallowed would range from $1.6 billion to $2.2 billion. Therefore, by limiting the amount of full-scope audits that were conducted, HCFA may have overpaid providers by as much as $600 million.

Potential Liability

The Health Care Financing Administration routinely processes and settles cost reports for institutional providers. As part of this process some providers have filed suits challenging aspects of the cost report settlement process. We cannot reasonably estimate the probability of the providers successfully winning their suits nor the potential liability for the Department. However, in the opinion of management, the resolution of these matters will not have a material impact on the results of operations and financial condition of HCFA.

Note 9: Total Program/Activity Costs (By Object Class) (Dollars in Millions)

	Medicare				CHIP and	Combined	Intra-HCFA	Consol.
	HI	SMI	Total	Medicaid	Others	Totals	Elim.	Total
Program Expenses								
Medicare Insurance Claims and Indemnities								
Fee for Service	$116,614	$60,405	$177,019			$177,019		$177,019
Managed Care	18,060	14,558	32,618			32,618		32,618
Payments to Health Care Trust Funds	5,259	59,775	65,034			65,034	(65,034)	
Medicaid Grants, Subsidies and Contributions				$97,864		97,864		97,864
Total Program Expenses	**$139,933**	**$134,738**	**$274,671**	**$97,864**		**$372,535**	**$(65,034)**	**$307,501**
Administrative Expenses								
Personal Services and Benefits	666	600	1,266	16	5	1,287		1,287
Contractual Services	580	835	1,415	74	2	1,491		1,491
Grants, Subsidies and Contrib.	8	16	24	2		26		26
Travel and Transportation	2	4	6			6		6
Rental, Communication and Util.	11	23	34	2		36		36
Printing and Reproduction	2	3	5	1		6		6
Supplies and Materials	1	2	3			3		3
Equipment	6	13	19	1		20		20
Total Administrative Expenses	**$1,276**	**$1,496**	**$2,772**	**$96**	**$7**	**$2,875**		**$2,875**
Other Expenses								
Medicare Integrity Program	607		607			607		607
Bad Debts and Write-offs	574	150	724	6		730		730
Depreciation and Amortization	3	5	8	1		9		9
Imputed Cost Subsidies	5	10	15			15		15
CLIA Program					69	69		69
Millennium (Y2K) Costs					30	30		30
Miscellaneous Expenses		1	1		1	2		2
Total Other Expenses	**$1,189**	**$166**	**$1,355**	**$7**	**$100**	**$1,462**		**$1,462**
Total Expenses	**$142,398**	**$136,400**	**$278,798**	**$97,967**	**$107**	**$376,872**	**$(65,034)**	**$311,838**

For purposes of financial statement presentation, administrative costs are considered expenses to the Medicare trust funds when outlayed by Treasury even though some funds may have been used to pay for assets such as property and equipment. In this regard, the Social Security Administration (SSA) reported $76.5 million of Property and Equipment, (Net) attributable to the Medicare program as of September 30, 1998. This amount is not included in HCFA's Consolidated Balance Sheet as assets related to the Medicare program. However, funds withdrawn from the trust funds by SSA during FY 1998 to pay for this activity are included in this section as an administrative expense to the Medicare program. The SSA administrative costs are reported to HCFA by Treasury. These expenses are also reported

included in this section as an administrative expense to the Medicare program. The SSA administrative costs are reported to HCFA by Treasury. These expenses are also reported by SSA on their FY 1998 Annual Financial Statement. HCFA's administrative costs have been allocated to the Medicare and Medicaid programs based on the HCFA cost allocation system. Administrative costs allocated to the Medicare program include $1.2 billion paid to Medicare contractors to carry out their responsibilities as HCFA's agents in the administration of the Medicare program.

The chart below details the Administrative Expenses by agency. HCFA is only one of several agencies that charge some administrative expenses to Medicare.

Administrative Expenses (Dollars in Millions)

	Medicare				CHIP and	Consolidated
	HI	SMI	Total	Medicaid	Others	Total
Administrative Expenses by Agency						
Treasury	$43		$43			$43
SSA	526	417	$943			$943
HCFA	520	1,024	$1,544	96	7	$1,647
Peer Review Organizations	177	44	$221			$221
Other	10	11	$21			$21
Total Administrative Expenses	**$1,276**	**$1,496**	**$2,772**	**$96**	**$7**	**$2,875**

Note 10: Premiums Collected and Federal Matching Contribution

SMI benefits and administrative expenses are financed by monthly premiums paid by Medicare beneficiaries and are matched by the Federal government through the general fund appropriation, Payments to the Health Care Trust Funds. Section 1844 of the Social Security Act authorizes appropriated funds to match SMI premiums collected, and outlines the ratio for the match as well as the method to make the trust funds whole if insufficient funds are available in the appropriation to match all premiums received in the fiscal year. The monthly SMI premium per beneficiary is $43.80 beginning January 1997. Premiums collected from beneficiaries totaled $19.4 billion in FY 1998 and were matched by a $59.8 billion contribution from the Federal government.

Note 11: Employment Tax Revenue

For periods after December 31, 1993, employees and employers are each required to contribute 1.45 percent of employees' wages, and self-employed persons are required to contribute 2.90 percent of net income, with no limitation, to the HI Trust Fund. The Social Security Act requires the transfer of these contributions from the General Fund of Treasury to the HI Trust Fund based on the amount of wages certified by the Commissioner of Social Security from SSA records of wages established and maintained by SSA in accordance with wage information reports. The SSA uses the wage totals reported annually by employers via the quarterly Internal Revenue Service Form 941 as the basis for conducting quarterly certification of regular wages.

Note 12: Other Revenues and Financing Sources (Dollars in Millions)

	Medicare		
	HI	SMI	Total
Fraud and Abuse Appropriation	$56		$56
Transfer-Uninsured Coverage	34		34
Program Management Admin. Expense *(1)*	102		102
Military Service Contribution	67		67
Income Tax OASDI Benefits	5,067		5,067
Railroad Retirement Principal	381		381
Civil/Criminal Fines and Penalties	107		107
Deposits by States	(2)		(2)
Gifts and Miscellaneous	1	$3	4
Total Other Revenues and Financing Sources	**$5,813**	**$3**	**$5,816**

(1) During FY 1998, the Payments to the Health Care Trust Funds appropriation paid the HI Trust Fund $102 million to cover the Medicaid program's share of HCFA's administrative costs.

Funds are obtained from the HI and SMI Trust Funds as cash is needed to pay for Program Management appropriation expenses. During FY 1998, a total of $1,631 million was obtained from the trust funds to cover cash outlays. Of this amount, $1,330 million was needed to pay for expenses incurred against current year obligations and $301 million was needed for expenses incurred against prior year obligations.

Note 13: Prior Period Adjustment (Dollars in Millions)

	Medicare				Consolidated
	HI	SMI	Total	Medicaid	Total
Total Prior Period Adjustments					
Reclassification of Equity Accounts	$(1)	$(6)	$(7)	$(1)	$(8)

OMB Circular 97-01 eliminated the "Invested Capital" and "Future Funding Requirements" lines from the Net Position section of the Balance Sheet. Balances previously held in these accounts have been closed out through a prior period adjustment.

Note 14: Increase in Unexpended Appropriations (Dollars in Millions)

	Medicare						Consolidated
	HI	SMI	Total	Medicaid	CHIP	Others	Total
Current Year Warrants and Anticipated Appropriations Exceeding Appropriated Capital Used	$6	$626	$632	$964	$4,235	$12	$5,843

The unexpended appropriations increased primarily due to year end obligations of funds for CHIP.

Note 15: Unobligated Balances, Obligations Incurred, & Obligated Balances

Due to the change in accounting policy with regard to liabilities, the adjustments obligating Entitlement Benefits Due and Payable to the general ledger for 1997 must be reversed. Beginning in 1998, a liability not covered by budgetary resources must be recorded as a contingent liability in HCFA's general ledger.

Note 16: Subsequent Event -Tobacco Settlement

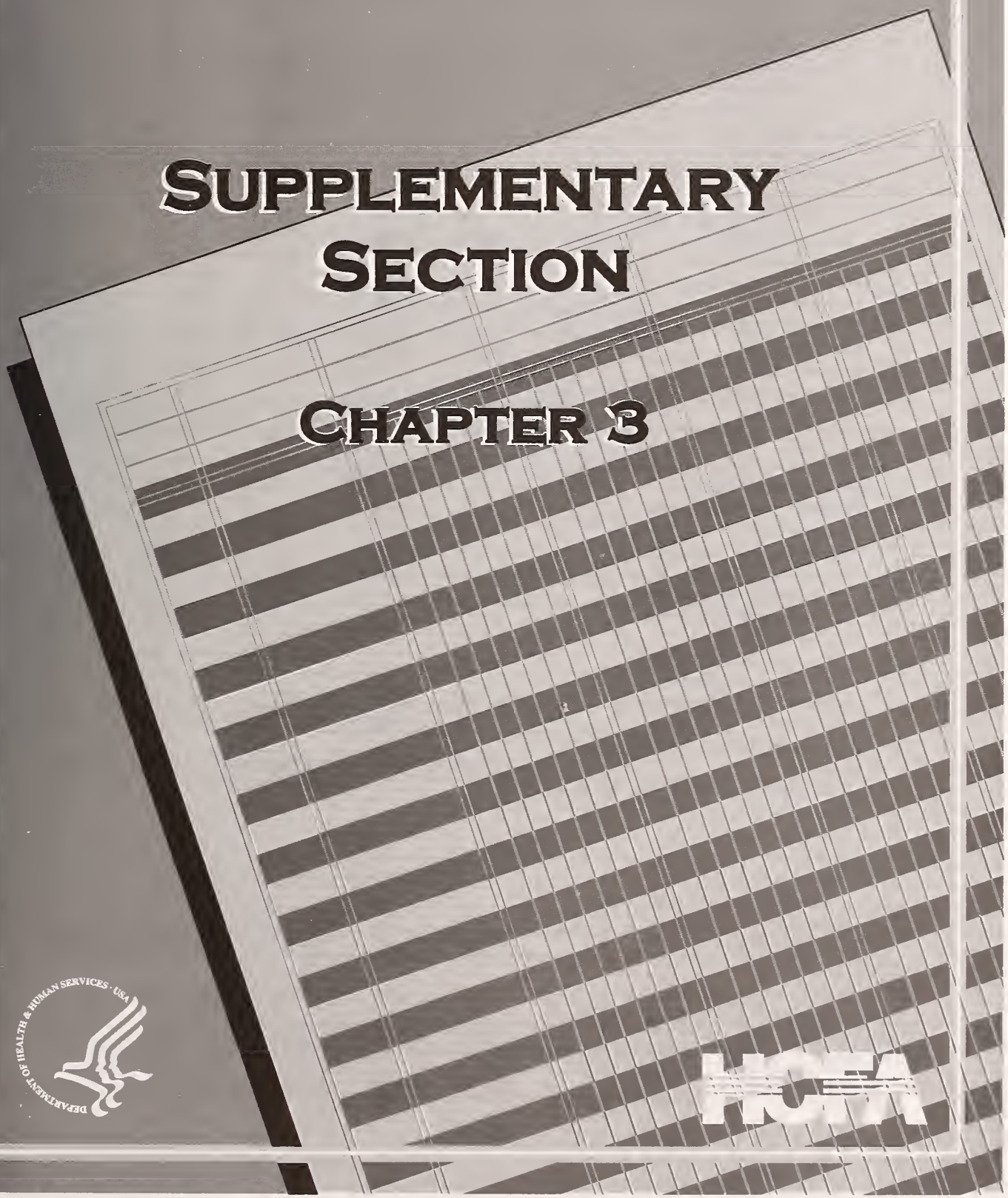
Subsequent to year end, certain States entered into a settlement agreement with tobacco companies for reimbursement of medical costs incurred in treating tobacco-related illnesses. Under Section 1903(d) of the Social Security Act, States must allocate from the amount of any Medicaid-related expenditures recovery, the pro-rata share to which the Federal government is entitled. The financial statements have not recognized a receivable for any proceeds as a result of the tobacco settlement since the final disposition of these funds has not been determined.

U.S. Department of Health and Human Services

Health Care Financing Administration

Supplementary Section

Chapter 3



CONSOLIDATING BALANCE SHEET
As of September 30, 1998 (in millions)

	MEDICARE		HEALTH			Combined
	HI	SMI	Medicaid	CHIP	Other	Total
ASSETS						
Entity Assets:						
Intragovernmental Assets:						
Fund Balances	$(1,312)	$2,211	$11,516	$4,230	$147	$16,792
Trust Fund (TF) Investments	118,250	39,502				157,752
Anticipated Transfer from SMI			200			200
TF Investment Interest Receivable	2,223	642				2,865
Accounts Receivable, Net	2	4	1			7
Total Intragovernmental Assets	119,163	42,359	11,717	4,230	147	177,616
Accounts Receivable, Net						
Medicare Secondary Payer (MSP)	146	99				245
Medicare Non-MSP	2,309	1,018				3,327
Other Accounts Receivable		2	31		4	37
Advances and Prepayments	28	1		5	4	38
Restricted Cash	5	46				51
Property and Equipment, Net	10	14	1			25
Total Entity Assets	**121,661**	**43,539**	**11,749**	**4,235**	**155**	**181,339**
Non-Entity Assets:						
Interest and Penalties Receivable, Net					**102**	**102**
TOTAL ASSETS	**$121,661**	**$43,539**	**$11,749**	**$4,235**	**$257**	**$181,441**
LIABILITIES						
Liabilities Covered by Budgetary Resources:						
Intragovernmental Liabilities:						
Liability for Allocation Transfer		$200				$200
Accounts Payable	$1	2	$1			4
Liabilities for Loan Guarantees					$3	3
Uncollected Revenue due Treasury	67	109			102	278
Other Intragovernmental Liabilities					13	13
Total Intragovernmental Liabilities	68	311	1		118	498
Accounts Payable	15	32	3			50
Suspense Accounts Deposit Funds					15	15
Accrued Payroll and Benefits	6	10	1			17
Entitlement Benefits Due and Payable	17,795	10,995	10,780			39,570
Other Liabilities	31	95				126
Total Liabilities Covered by Budgetary Resources	**17,915**	**11,443**	**10,785**		**133**	**40,276**
Liabilities not Covered by Budgetary Resources:						
Intragovernmental Liabilities:						
Accounts Payable		1				1
Accrued Leave	7	15	2			24
Other Liabilities	2	4				6
Total Liabilities not Covered by Budgetary Resources	**9**	**20**	**2**			**31**
TOTAL LIABILITIES	**$17,924**	**$11,463**	**$10,787**		**$133**	**$40,307**
NET POSITION						
Unexpended Appropriations	$15	$789	$964	$4,235	$40	$6,043
Cumulative Results of Operations	103,722	31,287	(2)		84	135,091
TOTAL NET POSITION	**$103,737**	**$32,076**	**$962**	**$4,235**	**$124**	**$141,134**
TOTAL LIABILITIES & NET POSITION	**$121,661**	**$43,539**	**$11,749**	**$4,235**	**$257**	**$181,441**

CONSOLIDATING BALANCE SHEET (continued) As of September 30, 1998 (in millions)	Combined Total	Intra-HCFA Eliminations	Consolidated Totals
ASSETS			
Entity Assets:			
Intragovernmental Assets:			
Fund Balances	$16,792		$16,792
Trust Fund (TF) Investments	157,752		157,752
Anticipated Transfer from SMI	200	$(200)	
TF Investment Interest Receivable	2,865		2,865
Accounts Receivable, Net	7		7
Total Intragovernmental Assets	177,616	(200)	177,416
Accounts Receivable, Net			
Medicare Secondary Payer (MSP)	245		245
Medicare Non-MSP	3,327		3,327
Other Accounts Receivable	37		37
Advances and Prepayments	38		38
Restricted Cash	51		51
Property and Equipment, Net	25		25
Total Entity Assets	**181,339**	**(200)**	**181,139**
Non-Entity Assets:			
Interest and Penalties Receivable, Net	**102**		**102**
TOTAL ASSETS	**$181,441**	**$(200)**	**$181,241**
LIABILITIES			
Liabilities Covered by Budgetary Resources:			
Intragovernmental Liabilities:			
Liability for Allocation Transfer	$200	$(200)	
Accounts Payable	4		$4
Liabilities for Loan Guarantees	3		3
Uncollected Revenue due Treasury	278		278
Other Intragovernmental Liabilities	13		13
Total Intragovernmental Liabilities	498	(200)	298
Accounts Payable	50		50
Suspense Accounts Deposit Funds	15		15
Accrued Payroll and Benefits	17		17
Entitlement Benefits Due and Payable	39,570		39,570
Other Liabilities	126		126
Total Liabilities Covered by Budgetary Resources	**40,276**	**(200)**	**40,076**
Liabilities not Covered by Budgetary Resources:			
Intragovernmental Liabilities:			
Accounts Payable	1		1
Accrued Leave	24		24
Other Liabilities	6		6
Total Liabilities not Covered by Budgetary Resources	**31**		**31**
TOTAL LIABILITIES	**$40,307**	**$(200)**	**$40,107**
NET POSITION			
Unexpended Appropriations	$6,043		$6,043
Cumulative Results of Operations	135,091		135,091
TOTAL NET POSITION	**$141,134**		**$141,134**
TOTAL LIABILITIES & NET POSITION	**$181,441**	**$(200)**	**$181,241**

CONSOLIDATING STATEMENT OF NET COST

Year Ended September 30, 1998	MEDICARE			HEALTH			Combined
(in millions)	HI	SMI	Total	Medicaid	CHIP	Other	Total
PROGRAM/ACTIVITY COSTS							
Benefit Payments *(Includes estimated improper payments of $7.8-$17.4 billion)*	$134,674	$74,963	$209,637	$97,864			$307,501
Medicare Integrity Program	607		607				607
Payments to the Health Care TF	5,259	59,775	65,034				65,034
Administrative Expenses	1,276	1,496	2,772	96	$3	$4	2,875
Bad Debts and Write-offs	574	150	724	6			730
Depreciation and Amortization	3	5	8	1			9
Imputed Cost Subsidies	5	10	15				15
CLIA Expenses							
Intragovernmental						33	33
With the Public						36	36
Millennium (Y2K) Costs						30	30
Miscellaneous Expenses		1	1			1	2
Total Program/Activity Costs	**142,398**	**136,400**	**278,798**	**97,967**	**3**	**104**	**376,872**
Less: Earned Revenues							
Premiums Collected	1,320	19,427	20,747				20,747
Medicare + Choice						95	95
CLIA User Fees Collected						45	45
Intragovernmental						3	3
With the Public						2	2
Total Earned Revenues	**1,320**	**19,427**	**20,747**			**145**	**20,892**
NET COST OF OPERATIONS	**$141,078**	**$116,973**	**$258,051**	**$97,967**	**$3**	**$(41)**	**$355,980**

CONSOLIDATING STATEMENT OF CHANGES IN NET POSITION

Year Ended September 30, 1998	MEDICARE			HEALTH			Combined
(in millions)	HI	SMI	Total	Medicaid	CHIP	Other	Total
Net Cost of Operations	**$141,078**	**$116,973**	**$258,051**	**$97,967**	**$3**	**$(41)**	**$355,980**
Financing Sources (other than exchange revenues):							
Appropriations Used	5,259	59,775	65,034	97,870			162,904
Employment Tax Revenue	121,915		121,915				121,915
Federal Matching Contribution		59,775	59,775				59,775
Interest on Trust Fund Investments	9,119	2,656	11,775				11,775
Trust Fund Draws	516	1,017	1,533	95	3		1,631
Revenue Transferred to Prog. Mgt.	(624)	(1,007)	(1,631)				(1,631)
Imputed Financing	5	10	15	1			16
Millennium (Y2K) Financing						30	30
Other Revenues & Financing Sources	5,813	3	5,816				5,816
Total Financing Sources	**142,003**	**122,229**	**264,232**	**97,966**	**3**	**30**	**362,231**
Net Results of Operations	**925**	**5,256**	**6,181**	**(1)**		**71**	**6,251**
Prior Period Adjustments	(1)	(6)	(7)	(1)			(8)
Net Change in Cumulative Results of Operations	**924**	**5,250**	**6,174**	**(2)**		**71**	**6,243**
Increase in Unexpended Approp.	6	626	632	964	4,235	12	5,843
Change in Net Position	**930**	**5,876**	**6,806**	**962**	**4,235**	**83**	**12,086**
Net Position-Beginning of Period	102,807	26,200	129,007			41	129,048
Net Position-End of Period	**$103,737**	**$32,076**	**$135,813**	**$962**	**$4,235**	**$124**	**$141,134**

CONSOLIDATING STATEMENT OF NET COST (continued) Year Ended September 30, 1998 (in millions)	Combined Total	Intra-HCFA Eliminations	Consolidated Totals
PROGRAM/ACTIVITY COSTS			
Benefit Payments *(Includes estimated improper payments of $7.8-$17.4 billion)*	$307,501		$307,501
Medicare Integrity Program	607		607
Payments to the Health Care TF	65,034	$(65,034)	$0
Administrative Expenses	2,875		2,875
Bad Debts and Write-offs	730		730
Depreciation and Amortization	9		9
Imputed Cost Subsidies	15		15
CLIA Expenses			
Intragovernmental	33		33
With the Public	36		36
Millennium (Y2K) Costs	30		30
Miscellaneous Expenses	2		2
Total Program/Activity Costs	**376,872**	**(65,034)**	**311,838**
Less: Earned Revenues			
Premiums Collected	20,747		20,747
Medicare + Choice	95		95
CLIA User Fees Collected	45		45
Intragovernmental	3		3
With the Public	2		2
Total Earned Revenues	**20,892**		**20,892**
NET COST OF OPERATIONS	**$355,980**	**$(65,034)**	**$290,946**

CONSOLIDATING STATEMENT OF CHANGES IN NET POSITION (continued) Year Ended September 30, 1998 (in millions)	Combined Total	Intra-HCFA Eliminations	Consolidated Totals
Net Cost of Operations	**$355,980**	**$(65,034)**	**$290,946**
Financing Sources (other than exchange revenues):			
Appropriations Used	162,904	(65,034)	97,870
Employment Tax Revenue	121,915		121,915
Federal Matching Contribution	59,775		59,775
Interest on Trust Fund Investments	11,775		11,775
Trust Fund Draws	1,631		1,631
Revenue Transferred to Prog. Mgt.	(1,631)		(1,631)
Imputed Financing	16		16
Millennium (Y2K) Financing	30		30
Other Revenues & Financing Sources	5,816		5,816
Total Financing Sources	**362,231**	**(65,034)**	**297,197**
Net Results of Operations	**6,251**		**6,251**
Prior Period Adjustments	(8)		(8)
Net Change in Cumulative Results of Operations	**6,243**		**0** **6,243**
Increase in Unexpended Approp.	5,843		5,843
Change in Net Position	**12,086**		**12,086**
Net Position-Beginning of Period	129,048		129,048
Net Position-End of Period	**$141,134**		**$141,134**

COMBINING STATEMENT OF BUDGETARY RESOURCES

Year Ended September 30, 1998 (in millions)	HI	SMI	HCFAC	Payments to Trust Funds	Program Mgt.
Budgetary Resources:					
Budget authority	$137,753	$81,955	$676	$66,027	$43
Unobligated balances - beginning of period	115,545	35,192	29	26	234
Net Transfers prior year balance, actual			(1)		
Spending authority from offsetting collections					1,888
Adjustments			5	(26)	58
Total Budgetary Resources	**$253,298**	**$117,147**	**$709**	**$66,027**	**$2,223**
Status of Budgetary Resources:					
Obligations incurred	136,536	76,272	679	65,178	2,031
Unobligated balances - available	116,762	40,875	16	849	53
Unobligated balances - not available			14		139
Total Status of Budgetary Resources	**$253,298**	**$117,147**	**$709**	**$66,027**	**$2,223**
Outlays:					
Obligations incurred	136,536	76,272	679	65,178	2,031
Less: spending authority from offsetting collections and adjustments			(5)		(1,985)
Obligated balance, net - beginning of period	505	13	57		495
Obligated balance transferred, net					(301)
Less: obligated balance, net- end of period	(352)	(14)	(122)		(280)
Total Outlays	**$136,689**	**$76,271**	**$609**	**$65,178**	**$(40)**

COMBINING STATEMENT OF BUDGETARY RESOURCES (continued)

Year Ended September 30, 1998 (in millions)	**Medicaid**	**CHIP**	**HMO Loan**	**Combined Totals**
Budgetary Resources:				
Budget authority	$99,591	$4,235	$(1)	$390,279
Unobligated balances - beginning of period	6,890		10	157,926
Net Transfers prior year balance, actual				(1)
Spending authority from offsetting collections	200		2	2,090
Adjustments	4,026			4,063
Total Budgetary Resources	**$110,707**	**$4,235**	**$11**	**$554,357**
Status of Budgetary Resources:				
Obligations incurred	104,495	3,750		388,941
Unobligated balances - available	6,212	485		165,252
Unobligated balances - not available			11	164
Total Status of Budgetary Resources	**$110,707**	**$4,235**	**$11**	**$554,357**
Outlays:				
Obligations incurred	104,495	3,750		388,941
Less: spending authority from offsetting collections and adjustments	(4,226)		(2)	(6,218)
Obligated balance, net - beginning of period	6,268			7,338
Obligated balance transferred, net				(301)
Less: obligated balance, net- end of period	(5,304)	(3,745)		(9,817)
Total Outlays	**$101,233**	**$5**	**$(2)**	**$379,943**

HOSPITAL INSURANCE TRUST FUND PROJECTIONS

(in billions)

Calendar Year	Total Income	Total Expenditures	Change in Fund	Fund at Year End	Assets to [1] Expenditures: (percent)
1997	$130.2	$139.5	-$9.3	$115.4	90
1998	135.9	143.6	-7.7	107.9	81
1999	140.4	147.2	-6.8	101.1	73
2000	145.0	149.5	-4.4	96.7	68
2001	150.6	153.8	-3.2	93.5	63
2002	156.5	160.6	-4.1	89.4	58
2003	163.1	170.1	-7.0	82.4	53
2004	170.2	180.9	-10.6	71.8	46
2005	178.1	193.3	-15.2	56.6	37
2006	186.0	206.7	-20.7	35.9	27
2007	194.8	221.2	-26.3	9.5	16

1

[1] Ratio of assets in the fund at the beginning of the year to expenditures during the year.

Note: Totals do not necessarily equal the sums of rounded components.

Reflects intermediate assumptions of the 1998 Annual Report of the Trustees of the HI Trust fund.

SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND PROJECTIONS

(in billions)

Calendar Year	Total Income	Total Expenditures	Change in Fund	Fund at Year End
1997	$81.9	$74.1	$7.8	$36.1
1998	80.6	82.6	-2.0	34.2
1999	88.1	88.4	-0.3	33.9
2000	97.5	97.5	0.0	34.0
2001	107.6	107.3	0.3	34.2
2002	118.6	118.0	0.6	34.8
2003	131.3	129.9	1.4	36.3
2004	143.3	142.4	0.9	37.2
2005	156.3	155.4	0.9	38.1
2006	173.3	169.3	4.0	42.1
2007	190.9	185.6	5.3	47.4

Reflects intermediate assumptions of the 1998 Annual Report of the Trustees of the SMI Trust fund.

FEDERAL MANAGERS' FINANCIAL INTEGRITY ACT

Material Weakness ***1. Financial Reporting - to properly account for Medicare Accounts Receivable and other financial information*** - The Medicare contractors are limited in their financial reporting because the systems for claims processing, their primary business function, were not designed to provide the financial data that HCFA needs, and, in most cases, lack general ledgers that incorporate double-entry bookkeeping. To compensate, HCFA designed quarterly financial reports to enable contractors to report financial data using their existing subsidiary systems. The OIG subsequently found that, contrary to HCFA instructions, many contractors and some regions were not reconciling the data they reported with existing information. The existing reports were not designed to include all categories of receivables and there is a time difference between when the receivable is recognized and when it is recorded. Difficulty following the "audit trail" is also partly due to some contractors failing to save the documentation required to support the reports, and, in one case, an inaccurate database.

The interim strategy has been to focus on improving internal controls to ensure HCFA instructions are followed and all appropriate reconciliations are completed. In addition, an effort was made to ensure the contractors and the auditors jointly knew what types of documentation were needed. The longer term strategy involves development of an integrated financial management system which will begin with a review of the current selected Medicare claims processing/financial systems to identify (1) the changes needed to current financial reporting from those systems and (2) the financial data not incorporated in the current selected systems.

Material Weakness ***2a. Systems Access Controls - to limit the number of database administrators (DBA) and applications developers can directly update production data.*** Direct command-line access to the M204 database had been granted to approximately 150 applications developers and DBAs. The M204 database product is used to store data for many of HCFA's sensitive applications, including the Automated Payment Plan System, Enrollment Database, and Group Health Plan applications. With the knowledge of file names and database update passwords, these developers can intentionally or inadvertently modify or update the data structures within specific regions of the M204 database.

As part of the HCFA Enterprise Systems Security initiative, we took steps to ensure that the data files containing sensitive information were placed into a protected library format and implemented a security utility for tracking the number of people having user passwords and the dates the passwords are changed. We are also improving the process to control M204 access via a commercial product that should be in place by December 1999. We will continue to enhance access controls through improvements in training, risk assessments, system administration, and internal audits.

Material Weakness ***2b. Systems Application Controls - Medicare Contractors*** - Three weaknesses were noted. (1) One fiscal intermediary had developed and implemented an override library to ensure that locally changed programs would have higher execution priorities over the standard Fiscal Intermediary Shared System (FISS) Programs provided by the FISS maintainer. (2) At a second fiscal intermediary, we noted that in addition to the Program Assistance Request (PAR) process, the programmers performed local changes to the FISS programs. Local modification are not subjected to the same documentation, authorization, testing, quality assurance, and other requirements present in the standard PAR process. (3) In a review of the Medicare Carrier System (MCS) it was noted that edits are fully controlled by carriers. The MCS application contains numerous edits and audits. Although the carriers do not have the MCS source code, the application, by design, allows them to deactivate almost all of the edits in the application, including mandatory HCFA edits.

The identified weaknesses related to the FISS and the MCS are currently being addressed. The specific local site that made the changes to the FISS code took actions to formally document the changes. The finding identified for the MCS system related to the exact duplicate edits and was fixed in April, 1998. As a long term solution, the process will be enhanced to limit overrides and to provide reasonable assurance that only authorized access to source code and programs is permitted. This will require the development and implementation of policies and procedures for safeguarding programs/systems that support claims processing and financial functions. Suggested control objectives have been provided to Medicare contractors for inclusion in their internal control certification process for FY 1999.

ADMINISTRATIVE FUNDING

HCFA's administrative costs are less than one percent of total expenditures. In the past, HCFA has been placed in a difficult position because the agency's resources have been straight-lined (in constant dollars) while the scope and magnitude of the programs it administers increased. This was caused by the budget scoring rules which totally separated mandatory and discretionary spending, with Medicare and Medicaid benefit dollars being on the mandatory side, while the money used to administer these programs was on the discretionary side. Thus, while the benefit payments were growing, the dollars available to administer them were not. Actions to remedy this situation have resulted in a variety of funding mechanisms. Most of HCFA's claims payment and management oversight operations are funded through an annual appropriation; certain quality control functions, primarily the Peer Review Organizations and the Medicare Integrity Programs, are funded through direct trust fund draws; and numerous other activities are funded through a variety of user fees. In 1998, administrative expenses were $2,875 million. HCFA spent $1,647 million and the balance was spent by other Federal agencies.

User fees are currently collected to fund the activities to (1) develop and disseminate comparative health plan information, (2) survey and certify laboratories under CLIA, (3) pay for sales of data from HCFA's numerous databases, and (4) pay for sales of FOIA material. Unless set by statute, these fees are set to cover the costs of doing business and are reassessed at least every two years. Income received from user fees in 1998 ranged from slightly under $200,000 for FOIA, to $30 million for CLIA, and $95 million for Medicare+Choice. Beginning in 1998, a legislatively mandated user fee was collected monthly from each managed care organization to implement the BBA information provisions of Medicare+Choice designed to enhance beneficiary choices.

Statement of Account for HI Trust Fund Investments

U. S. TREASURY SPECIAL ISSUES

U. S. Treasury Special Issues: Certificates of Indebtedness:	Amount Issued	Less Amount Retired	Net Amount Outstanding
5.750% maturing June 30, 1999	$18,427,914,000	$18,427,914,000	$0
5.375% maturing June 30, 1999	$12,017,702,000	$9,570,610,000	$2,447,092,000
Total	**$30,445,616,000**	**$27,998,524,000**	**$2,447,092,000**

Bonds:	Amount Issued	Less Amount Retired	Net Amount Outstanding
13.750% due June 30, 1999	850,544,000	0	850,544,000
10.375% due June 30, 2000	1,277,566,000	0	1,277,566,000
10.375% due June 30, 1999	427,022,000	0	427,022,000
9.250% due June 30, 2003	4,229,944,000	0	4,229,944,000
9.250% due June 30, 2002	1,034,542,000	0	1,034,542,000
9.250% due June 30, 2001	1,034,542,000	0	1,034,542,000
9.250% due June 30, 2000	1,034,542,000	0	1,034,542,000
9.250% due June 30, 1999	1,034,542,000	207,829,000	826,713,000
8.750% due June 30, 2005	6,415,695,000	0	6,415,695,000
8.750% due June 30, 2004	6,415,695,000	0	6,415,695,000
8.750% due June 30, 2003	2,185,751,000	0	2,185,751,000
8.750% due June 30, 2002	2,185,751,000	0	2,185,751,000
8.750% due June 30, 2001	2,185,751,000	0	2,185,751,000
8.750% due June 30, 2000	2,185,751,000	0	2,185,751,000
8.750% due June 30, 1999	2,185,751,000	2,185,751,000	0
8.625% due June 30, 2002	3,195,402,000	0	3,195,402,000
8.625% due June 30, 2001	686,250,000	0	686,250,000
8.625% due June 30, 2000	686,250,000	0	686,250,000
8.625% due June 30, 1999	686,250,000	686,250,000	0
8.375% due June 30, 2001	2,509,152,000	0	2,509,152,000
8.375% due June 30, 2000	1,231,586,000	0	1,231,586,000
8.375% due June 30, 1999	1,231,586,000	1,231,586,000	0
8.125% due June 30, 2006	7,316,968,000	103,302,000	7,213,666,000
8.125% due June 30, 2005	901,273,000	0	901,273,000
8.125% due June 30, 2004	901,273,000	0	901,273,000
8.125% due June 30, 2003	901,273,000	0	901,273,000
8.125% due June 30, 2002	901,274,000	0	901,274,000
8.125% due June 30, 2001	901,274,000	0	901,274,000
8.125% due June 30, 2000	901,274,000	0	901,274,000
8.125% due June 30, 1999	901,274,000	797,972,000	103,302,000
7.375% due June 30, 2007	8,184,929,000	0	8,184,929,000
7.375% due June 30, 2006	867,961,000	0	867,961,000
7.375% due June 30, 2005	867,961,000	0	867,961,000
7.375% due June 30, 2004	867,961,000	0	867,961,000
7.375% due June 30, 2003	867,961,000	0	867,961,000
7.375% due June 30, 2002	867,960,000	0	867,960,000

Continued

U. S. TREASURY SPECIAL ISSUES (continued)

Bonds:	Amount Issued	Less Amount Retired	Net Amount Outstanding
7.375% due June 30, 2001	$867,960,000	$0	$867,960,000
7.375% due June 30, 2000	$867,961,000	$0	$867,961,000
7.375% due June 30, 1999	$867,961,000	$867,961,000	$0
7.250% due June 30, 2009	$8,773,256,000	$0	$8,773,256,000
7.250% due June 30, 2008	$225,130,000	$0	$225,130,000
7.250% due June 30, 2007	$225,130,000	$0	$225,130,000
7.250% due June 30, 2006	$225,129,000	$0	$225,129,000
7.250% due June 30, 2005	$225,129,000	$0	$225,129,000
7.250% due June 30, 2004	$225,129,000	$0	$225,129,000
7.250% due June 30, 2003	$225,129,000	$0	$225,129,000
7.250% due June 30, 2002	$225,129,000	$0	$225,129,000
7.250% due June 30, 2001	$225,129,000	$0	$225,129,000
7.250% due June 30, 2000	$225,129,000	$0	$225,129,000
7.000% due June 30, 2011	$3,368,466,000	$0	$3,368,466,000
6.875% due June 30, 2011	$2,166,172,000	$0	$2,166,172,000
6.500% due June 30, 2010	$9,037,246,000	$0	$9,037,246,000
6.500% due June 30, 2009	$263,990,000	$0	$263,990,000
6.500% due June 30, 2008	$263,990,000	$0	$263,990,000
6.500% due June 30, 2007	$263,990,000	$0	$263,990,000
6.500% due June 30, 2006	$263,990,000	$0	$263,990,000
6.500% due June 30, 2005	$263,990,000	$0	$263,990,000
6.500% due June 30, 2004	$263,990,000	$0	$263,990,000
6.500% due June 30, 2003	$263,990,000	$0	$263,990,000
6.500% due June 30, 2002	$263,990,000	$0	$263,990,000
6.500% due June 30, 2001	$263,990,000	$0	$263,990,000
6.500% due June 30, 2000	$263,990,000	$0	$263,990,000
6.250% due June 30, 2008	$8,548,126,000	$0	$8,548,126,000
6.250% due June 30, 2007	$363,197,000	$0	$363,197,000
6.250% due June 30, 2006	$363,198,000	$0	$363,198,000
6.250% due June 30, 2005	$363,198,000	$0	$363,198,000
6.250% due June 30, 2004	$363,198,000	$0	$363,198,000
6.250% due June 30, 2003	$363,198,000	$0	$363,198,000
6.250% due June 30, 2002	$363,198,000	$0	$363,198,000
6.250% due June 30, 2001	$363,198,000	$0	$363,198,000
6.250% due June 30, 2000	$363,197,000	$0	$363,197,000
5.875% due June 30, 2012	$11,272,706,000	$2,518,249,000	$8,754,457,000
Total Bonds	**$124,401,980,000**	**$8,598,900,000**	**$115,803,080,000**
Total Treasury Special Issues	**$154,847,596,000**	**$36,597,424,000**	**$118,250,172,000**

STATEMENT OF ACCOUNT FOR SMI TRUST FUND INVESTMENTS

U. S. TREASURY SPECIAL ISSUES:

Certificates of Indebtedness:	Amount Issued	Less Amount Retired	Net Amount Outstanding
5.750% maturing June 30, 1999	$16,886,460,000	$15,305,695,000	$1,580,765,000
5.375% maturing June 30, 1999	$7,417,342,000	$5,572,150,000	$1,845,192,000
Total	$24,303,802,000	$20,877,845,000	$3,425,957,000

Bonds:	Amount Issued	Less Amount Retired	Net Amount Outstanding
8.750% due June 30, 2005	991,433,000	0	991,433,000
8.750% due June 30, 2004	991,433,000	0	991,433,000
8.750% due June 30, 2003	991,433,000	0	991,433,000
8.750% due June 30, 2002	991,433,000	199,508,000	791,925,000
8.125% due June 30, 2006	1,218,813,000	0	1,218,813,000
8.125% due June 30, 2005	227,380,000	0	227,380,000
8.125% due June 30, 2004	227,381,000	0	227,381,000
8.125% due June 30, 2003	227,381,000	0	227,381,000
7.375% due June 30, 2007	1,293,107,000	0	1,293,107,000
7.375% due June 30, 2006	74,295,000	0	74,295,000
7.375% due June 30, 2005	74,295,000	0	74,295,000
7.375% due June 30, 2004	74,294,000	0	74,294,000
7.375% due June 30, 2003	74,294,000	0	74,294,000
7.250% due June 30, 2009	1,570,476,000	0	1,570,476,000
7.250% due June 30, 2008	47,113,000	0	47,113,000
7.250% due June 30, 2007	47,112,000	0	47,112,000
7.250% due June 30, 2006	47,112,000	0	47,112,000
7.250% due June 30, 2005	47,112,000	0	47,112,000
7.250% due June 30, 2004	47,112,000	0	47,112,000
7.250% due June 30, 2003	47,112,000	0	47,112,000
7.000% due June 30, 2011	1,659,860,000	0	1,659,860,000
7.000% due June 30, 2010	1,659,860,000	0	1,659,860,000
7.000% due June 30, 2009	89,384,000	0	89,384,000
7.000% due June 30, 2008	89,384,000	0	89,384,000
7.000% due June 30, 2007	89,384,000	0	89,384,000
7.000% due June 30, 2006	89,385,000	0	89,385,000
7.000% due June 30, 2005	89,385,000	0	89,385,000
7.000% due June 30, 2004	89,385,000	0	89,385,000
7.000% due June 30, 2003	89,385,000	0	89,385,000
7.000% due June 30, 2002	867,936,000	0	867,936,000
7.000% due June 30, 2001	1,659,861,000	0	1,659,861,000
7.000% due June 30, 2000	1,659,861,000	0	1,659,861,000
7.000% due June 30, 1999	1,659,861,000	956,454,000	703,407,000
7.000% due June 30, 1998	1,659,861,000	1,659,861,000	0
6.875% due June 30, 2012	2,227,470,000	567,609,000	1,659,861,000
6.875% due June 30, 2011	567,610,000	0	567,610,000
6.875% due June 30, 2010	567,610,000	0	567,610,000
6.875% due June 30, 2009	567,610,000	0	567,610,000
6.875% due June 30, 2008	567,610,000	0	567,610,000

continued

U. S. TREASURY SPECIAL ISSUES (continued)

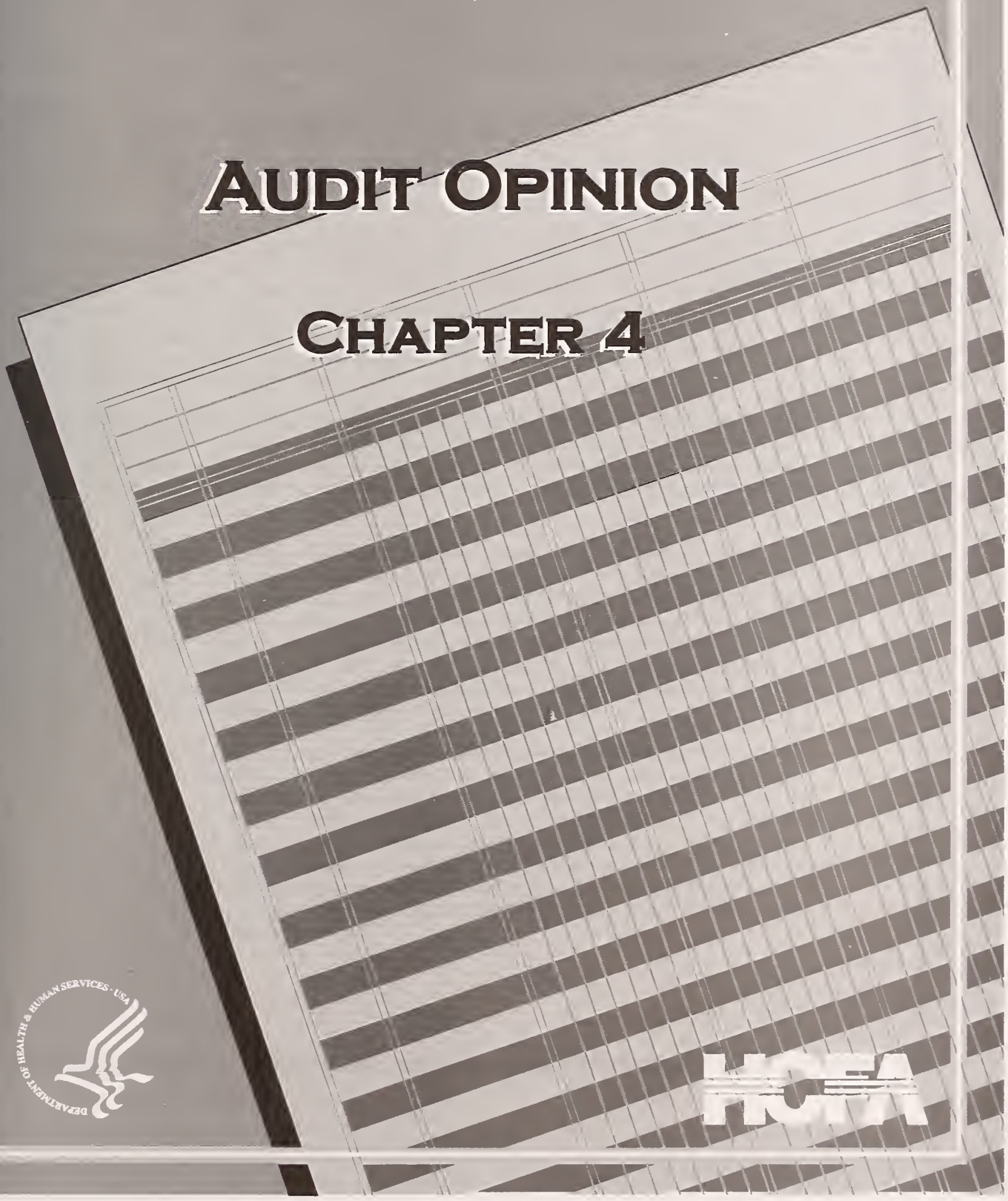
Bonds:	Amount Issued	Less Amount Retired	Net Amount Outstanding
6.875% due June 30, 2007	$567,610,000	$0	$567,610,000
6.875% due June 30, 2006	$567,609,000	$0	$567,609,000
6.875% due June 30, 2005	$567,609,000	$0	$567,609,000
6.875% due June 30, 2004	$567,609,000	$0	$567,609,000
6.875% due June 30, 2003	$567,609,000	$0	$567,609,000
6.875% due June 30, 2002	$567,609,000	$0	$567,609,000
6.875% due June 30, 2001	$567,609,000	$0	$567,609,000
6.875% due June 30, 2000	$567,609,000	$0	$567,609,000
6.875% due June 30, 1999	$567,609,000	$0	$567,609,000
6.250% due June 30, 2008	$1,523,363,000	$0	$1,523,363,000
6.250% due June 30, 2007	$230,257,000	$0	$230,257,000
6.250% due June 30, 2006	$230,256,000	$0	$230,256,000
6.250% due June 30, 2005	$230,256,000	$0	$230,256,000
6.250% due June 30, 2004	$230,256,000	$0	$230,256,000
6.250% due June 30, 2003	$230,256,000	$0	$230,256,000
5.875% due June 30, 2013	$6,714,226,000	$299,117,000	$6,415,109,000
Total Bonds	$39,758,175,000	$3,682,549,000	$36,075,626,000
Total Treasury Special Issues	$64,061,977,000	$24,560,394,000	$39,501,583,000

U.S. Department of Health and Human Services

Health Care Financing Administration

Audit Opinion

Chapter 4



DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Memorandum

Date FEB 26 1999

From for June Gibbs Brown
Inspector General

Subject Report on the Financial Statement Audit of the Health Care Financing Administration for Fiscal Year 1998 (CIN: A-17-98-00098)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

The attached final report presents the results of the audit of the Fiscal Year (FY) 1998 financial statements of the Health Care Financing Administration (HCFA). The firm Ernst & Young LLP (E&Y) undertook the audit in support of the Departmentwide financial statement audit by the Office of Inspector General (OIG) and in accordance with the Government Reform Act of 1994. The OIG exercised technical oversight and quality control of the audit. The overall audit objective was to determine whether the HCFA principal financial statements were fairly presented in all material respects.

Except for the effect of the matter discussed below, HCFA's financial statements present fairly, in all material respects, the financial position of HCFA as of September 30, 1998; the consolidated net costs and changes in net position; and the combined budgetary resources and financing for the year then ended in accordance with the accounting principles described in note 1 to those financial statements.

- **Medicare Accounts Receivable.** Medicare contractors used systems for processing claims that did not have general ledger capabilities for Medicare program activity, and they reported accounts receivable activity to HCFA in periodic financial reports based on subsidiary records maintained on ad hoc spreadsheets. The contractors reported over $22.9 billion of Medicare accounts receivable activity during the year, resulting in a reported gross accounts receivable of approximately $5.8 billion and net accounts receivable of $3.3 billion, which represents approximately 90 percent of the $3.6 billion of total Medicare accounts receivable at September 30, 1998.

  We found deficiencies in nearly all facets of Medicare accounts receivable activity at the 12 contractors in our sample. Some contractors were unable to support the beginning balances, others reported incorrect activity, including collections, and finally others were unable to reconcile their reported ending balances to subsidiary records. We also found that substantial amounts of receivables had been settled with insurance companies for Medicare payments related to situations in which Medicare was the secondary payer but were still presented as outstanding accounts receivable. E&Y was unable to satisfy itself as to Medicare contractors' accounts receivable balances and activities as of and for the year ended September 30, 1998.

Page 2 - Nancy-Ann Min DeParle

The report on internal controls notes three material weaknesses: (1) Medicare accounts receivable, discussed above, (2) financial reporting, and (3) electronic data processing access and application development and change controls.

The firm has incorporated HCFA's comments on the draft of this report where appropriate. Officials in your office have concurred with the recommendations and are in the process of taking corrective action. We would like to thank you and your staff for the outstanding cooperation and assistance in working with us and E&Y on these most complex and challenging problems.

We would appreciate your views and information on the status of any action taken or contemplated on the recommendations within the next 60 days. If you have any questions, please contact me or have your staff contact Joseph E. Vengrin, Assistant Inspector General for Audit Operations and Financial Statement Activities, at (202) 619-3157.

To facilitate identification, please refer to Common Identification Number A-17-98-00098 in all correspondence relating to this report.

Attachment

cc:
John J. Callahan
Assistant Secretary
for Management and Budget

George H. Strader
Deputy Assistant Secretary, Finance

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REPORT ON THE FINANCIAL STATEMENT AUDIT OF THE HEALTH CARE FINANCING ADMINISTRATION FOR FISCAL YEAR 1998

JUNE GIBBS BROWN
Inspector General

FEBRUARY 1999
A-17-98-00098

ERNST & YOUNG LLP ■ 1225 Connecticut Avenue, N.W. Washington, D.C. 20036 ■ Phone: 202 327 6000

Report of Independent Auditors

To the Inspector General of the
Department of Health and Human Services
and the Administrator of the Health Care Financing Administration

We have audited the accompanying consolidated balance sheet of the Health Care Financing Administration (HCFA) as of September 30, 1998, the related consolidated statements of net cost and changes in net position and combined statements of budgetary resources and financing for the year then ended. These financial statements are the responsibility of HCFA's management. Our responsibility is to express an opinion on these financial statements based on our audit. The Medicaid Program, a major HCFA administered program, had total assets of $11.7 billion as of September 30, 1998 and total net costs of $97.9 billion for the year then ended. The Medicaid Program financial information, which is included in HCFA's consolidated and combined financial statements, was audited by other auditors whose report has been furnished to us, and our opinion, insofar as it relates to Medicaid financial information, is based solely on the report of the other auditors.

Except as discussed in the following paragraph, we conducted our audit in accordance with generally accepted auditing standards; *Government Auditing Standards* issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 98-08, *Audit Requirements for Federal Financial Statements* (as amended). These standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit and the report of other auditors provide a reasonable basis for our opinion.

HCFA reported net accounts receivable of $3.6 billion at September 30, 1998, of which $3.3 billion was attributable to Medicare contractors. Medicare contractors use systems for processing claims that do not have general ledger capabilities for Medicare Program activity and they report accounts receivable activity to HCFA in periodic financial reports based upon subsidiary records maintained on ad-hoc spreadsheets. The contractors reported over $22.9 billion of Medicare accounts receivable activity during the year resulting in a reported gross accounts receivable of approximately $5.8 billion and net accounts receivable of $3.3 billion at September 30, 1998. We found deficiencies in nearly all facets of Medicare accounts receivable activity at the twelve contractors in our sample. Some contractors were unable to support the beginning balances, others reported incorrect activity, including collections, and finally others were unable to reconcile their reported ending balances to subsidiary records. We also found substantial amounts of receivables that had been settled with insurance companies for Medicare payments related to situations in which Medicare is the secondary payer (MSP), but, were still presented as

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outstanding accounts receivable. Existing internal controls were not adequate to identify receivables that are part of the settlement agreements. We were unable to satisfy ourselves as to Medicare contractors' accounts receivable balances and activities as of and for the year ended September 30, 1998.

As described in Note 1, HCFA prepared its financial statements in conformity with the hierarchy of accounting principles and standards approved by the Federal Accounting Standards Advisory Board. The hierarchy is a comprehensive basis of accounting other than generally accepted accounting principles.

In our opinion, based on our audit and the report of the other auditors, except for the effects of adjustments to the financial statements, if any, that might have been determined to be necessary had we been able to examine evidence supporting the Medicare accounts receivable and related activity as of, and for the year ended, September 30, 1998, the financial statements referred to above present fairly, in all material respects, the financial position of HCFA as of September 30, 1998, the consolidated net costs and changes in net position, and combined budgetary resources and financing for the year then ended in accordance with the accounting principles described in Note 1 to those financial statements.

Our audit was conducted for the purpose of forming an opinion on the financial statements referred to in the first paragraph. The information presented in the Overview of HCFA and the Supplemental Information of HCFA is not a required part of the principal financial statements, but is supplementary information required by Office of Management and Budget Bulletin 97-01, *Form and Content of Agency Financial Statements*. Such information, including trust fund projections, has not been subjected to the auditing procedures applied in the audit of the Financial Statements, and accordingly, we express no opinion on it.

In accordance with Government Auditing Standards, we have issued our reports dated January 29, 1999, on our consideration of HCFA's internal controls and on its compliance with applicable laws and regulations.

Ernst & Young LLP

January 29, 1999

ERNST & YOUNG LLP ■ 1225 Connecticut Avenue, N.W. Washington, D.C. 20036 ■ Phone: 202 327 6000

Report of Independent Auditors on Internal Control

To the Inspector General of the
Department of Health and Human Services
and the Administrator of the Health Care Financing Administration

We have audited the consolidated balance sheet of the Health Care Financing Administration (HCFA) as of September 30, 1998, the related consolidated statements of net cost and changes in net position and combined statements of budgetary resources and financing for the year then ended. The Medicaid Program, a major HCFA administered program, had total assets of $11.7 billion as of September 30, 1998 and total net costs of $97.9 billion for the year then ended. The Medicaid Program financial information, which is included in HCFA's consolidated and combined financial statements, was audited by other auditors whose report has been furnished to us, and our opinion, insofar as it relates to Medicaid financial information, is based solely on the report of the other auditors. Our report, dated January 29, 1999, on HCFA's consolidated and combined financial statements was qualified for the effects of such adjustments, if any, that might have been determined to be necessary had we been able to examine evidence supporting the Medicare accounts receivable and related activity as of, and for the year ended, September 30, 1998.

Except for the matters discussed in the third paragraph of our report on the financial statements, we conducted our audit in accordance with generally accepted auditing standards; *Government Auditing Standards*, issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 98-08, *Audit Requirements for Federal Financial Statements* (as amended). These standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements referred to above are free of material misstatement.

In planning and performing our audit of the financial statements of HCFA, as of and for the year ended September 30, 1998, we obtained an understanding of internal control in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statements and to determine whether the internal controls meet the objectives identified in the following paragraph. Our consideration included obtaining an understanding of the significant internal control policies and procedures and assessing the level of control risk relevant to all significant cycles, classes of transactions, or account balances; and for those significant internal control policies and procedures that have been properly designed and placed in operation, performing sufficient tests to assess more fully whether the controls are effective and working as designed to determine our auditing procedures for the purpose of expressing our opinion on the financial statements and not to provide an opinion on internal control. Accordingly, we do not express such an opinion.

The management of HCFA is responsible for establishing and maintaining internal control. In fulfilling this responsibility, estimates and judgments by management are required to assess the expected benefits and related costs on internal control policies and procedures. The objectives of internal control are to provide management with reasonable, but not

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absolute, assurance that assets are safeguarded against loss from unauthorized use or disposition, and that transactions are executed in accordance with management's authorization and recorded properly to permit the preparation of financial statements in accordance with the hierarchy of accounting principles and standards approved by the principals of the Federal Accounting Standards Advisory Board; and data that support reported performance measures are properly recorded and accounted for to permit preparation of reliable and complete performance information. Because of inherent limitations in any internal control, errors and irregularities may nevertheless occur and not be detected. Also, projection of any evaluation of internal control to future periods is subject to the risk that procedures may become inadequate because of changes in conditions or that the effectiveness of the design and operation of policies and procedures may deteriorate. In addition, with respect to internal controls related to performance measures reported in the overview of the reporting entity, we obtained an understanding of the design of significant internal controls relating to the existence and completeness assertions, as required by OMB Bulletin 98-08. Our procedures were not designed to provide assurance on internal control over reported performance measures, and, accordingly, we do not provide an opinion on such controls.

We noted certain matters involving internal control and its operation that we consider to be reportable conditions under standards established by the American Institute of Certified Public Accountants and OMB Bulletin 98-08, *Audit Requirements for Federal Financial Statements*. Reportable conditions involve matters coming to our attention relating to significant deficiencies in the design or operation of internal control that, in our judgment, could adversely affect the entity's ability to record, process, summarize, and report financial data consistent with the assertions of management in the financial statements.

A material weakness is a reportable condition in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that errors or irregularities in amounts that would be material in relation to the financial statements being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions.

Our consideration of internal control would not necessarily disclose all matters in internal control which might be reportable conditions and, accordingly, would not necessarily disclose all reportable conditions that are also considered to be material weaknesses as defined above. We have described the reportable conditions below, the first three of which were considered material weaknesses as defined above.

Material Weakness 2 was not identified as such by HCFA in the Draft Department of Health and Human Services (DHHS) FY 1998 Federal Managers Financial Integrity Act (FMFIA) report. Significant components of each of these material weaknesses were reported in previous Chief Financial Officers (CFO) audit reports and remain uncorrected.

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Material Weaknesses

1. Medicare Accounts Receivable *(Repeat Condition)*

For the year ended September 30, 1998, HCFA reported over $34.7 billion of accounts receivable activity and a net account receivable balance of $3.6 billion. The net accounts receivable balance was comprised of gross outstanding accounts receivable of $7.4 billion and an allowance for uncollectible accounts of $3.8 billion. Medicare accounts receivable primarily represent funds owed by providers to HCFA due to overpayments, as well as funds due from other entities in instances in which Medicare is the secondary payer (MSP) of claims. HCFA's contractors are responsible for reporting and collecting the majority of these receivables (over 75 percent of the outstanding balance at year end). The remainder of the balance is managed by HCFA's central office and regional offices.

In connection with the FY 1998 audit, we performed procedures related to accounts receivable activity at 12 of the Medicare contractors. We performed similar visits in prior years. Based on our visits, we concluded that the Medicare contractors in aggregate did not have adequate subsidiary records and other documentation to support the over $22.9 billion of accounts receivable activity they processed, i.e., a Non-MSP portion of $9.5 billion of new accruals, $7.3 billion of collections and $580 million of adjustments, and an MSP portion of $653 million of new accruals, $224 million of collections and $520 million of accounts receivable adjustments. Specifically, we noted the following:

Medicare Secondary Payer Accounts Receivable

HCFA reported gross MSP accounts receivable of $1.8 billion at September 30, 1998 and the related allowance for uncollectible accounts of $1.5 billion. We found deficiencies in nearly all facets of MSP activity reported by the 12 Medicare contractors tested during FY 1998. For example, three contractors could not provide subsidiary records reconciling to the beginning balance, seven contractors were not able to adequately support current year activity and five contractors could not support adjustments, including reclassifications, to detailed records. We also found that five contractors were not able to reconcile their subsidiary records to amounts reported for MSP to HCFA, as of September 30, 1998. Additionally, HCFA considers the collectability of MSP accounts receivable as doubtful and provided an allowance for uncollectible accounts equivalent to 86 percent for the MSP accounts receivable balance. It is not clear the extent to which this collection history reflects inappropriate recognition of accounts receivable versus insufficient collection/offset efforts, or the extent to which all MSP activity is captured.

MSP Settlement Agreements - HCFA has executed settlement agreements with several insurance companies for MSP overpayments. As of September 30, 1998, the amount of accounts receivable that are related to these settlements has not been determined and

adjusted to reflect collections and settlement activity. Consequently, these settled amounts are still reported as outstanding accounts receivable at year end. HCFA is currently in the process of identifying and resolving these settled amounts.

MSP - Applicability of SFFAS No. 1 - HCFA procedures for recognizing certain MSP accounts receivable are under review for potential inconsistencies with standards as described in Statement of Federal Financial Accounting Standard (SFFAS) No. 1, *Accounting for Selected Assets and Liabilities* and SFFAS No. 7, *Accounting for Revenue and Other Financing Sources and Concept for Reconciling Budgetary and Financial Accounting*. These standards recognize accounts receivable when they are specifically identifiable, measurable and legally enforceable. However, we found that HCFA recognizes accounts receivable prior to meeting all the criteria required by these standards potentially overstating reported accounts receivable.

Non-MSP Accounts Receivable

Medicare contractors managed approximately $4 billion of gross Non-MSP accounts receivable at September 30, 1998. At year end, the 12 contractors in our sample managed gross Non-MSP accounts receivable of approximately $1.8 billion. Overall, the Medicare contractors have made improvements in maintaining supporting records for Non-MSP related activity and year end balances. However, we found that independent verification controls were not established to provide reasonable assurance that amounts reported by contractors to HCFA were valid, accurately summarized and sufficiently documented. Specifically, we found that 10 of the 12 contractors in our sample reported incorrect Non-MSP activity, including collections during the year. Some of the deficiencies noted in accounting for Non-MSP activity during FY 1998 are presented below:

- Two contractors in our sample were not able to support over $4 million in adjustments to their beginning Non-MSP accounts receivable balance reported to HCFA.
- Two contractors had unreconciled variances of more than $44.7 million and $11.9 million, respectively, for cost settlements reported to HCFA.
- One contractor reported approximately $2 million in reclassifications to cost settlements that were not supported by detailed records.
- One contractor reported over $5 million in current year activity that was not supported by detailed records.
- One contractor reported $147 million in collections that were not supported by detailed records.

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- One contractor reported over $4.5 million in Medicare reclassifications that were not supported by subsidiary records.

- One contractor transferred approximately $495,000 of Non-MSP accounts receivable that lacked proper detailed subsidiary records to another contractor.

In addition to the deficiencies noted above, we found that when new Non-MSP activity and collections were accounted for by the contractors, the record keeping was not performed on a timely basis. HCFA's collections history with respect to Non-MSP activity has given rise to an allowance for uncollectible accounts of more than 40 percent of the outstanding balance, calling into question the collection efforts applied and/or the process used to estimate and record such accounts receivable.

Lack of Integrated Financial Management System for Accounts Receivable and Claims Activity

OMB Circular No. A-127, *Financial Management Systems*, requires Federal agencies to have an integrated financial management system that provides effective and efficient interrelationships between software, hardware, personnel, procedures, controls, and data contained within the systems. The lack of an integrated financial management system continues to impair HCFA's and the Medicare contractors' abilities to adequately support the accounts receivable activity and balances reported.

Medicare contractors' claims processing systems do not have general ledger capabilities. Accounts receivable balances reported by the contractors are generally maintained on personal computer (PC) based software. In FY 1998, over $177 billion of Medicare benefit payments and $22.9 billion of accounts receivable activity were processed by the Medicare contractors. The claims processing systems lack the capability to properly classify, summarize and report Medicare transactions in accordance with the requirements of OMB A-127. As a result, we found unsubstantiated adjustments to beginning accounts receivable balances, reclassifications and adjustments to current year records in order to reconcile the Medicare contractors' records to amounts reported to HCFA. We also found that 9 of the 12 contractors in our sample did not reconcile subsidiary records to amounts reported to HCFA.

Medicare Contractors Controls Over Cash including Collections of Outstanding Accounts Receivable

Typically, controls are designed to protect assets against theft, loss, misuse, or unauthorized alteration and to reduce the opportunities for the occurrence and concealment of errors or irregularities. We reviewed the contractors' cash procedures to determine whether adequate safeguards and records were in place and whether duties were properly segregated. During FY 1998, Medicare contractors reported over $7.5 billion of collections. We found the following deficiencies similar to those identified in prior years:

- Medicare contractors did not maintain subsidiary records to support cash collections and balances reported.

- Medicare contractors did not properly segregate duties for cash responsibilities. For example, at one of our test locations, the same individuals were responsible for receiving and endorsing incoming checks, preparing and recording deposits, and performing bank reconciliations.

- In many cases, Medicare contractors did not prepare bank reconciliations in a timely manner and, when prepared, the bank reconciliations were not adequately documented.

- At one of the 12 Medicare contractors tested, Medicare blank checks were not properly secured and the access to blank checks was not always limited.

Recommendations

We recommend that HCFA reengineer its processes to account for and pursue the collection of MSP accounts receivable and continue to build on the progress made in improving Non-MSP accounts receivable systems. Specifically, we recommend that the following procedures be implemented:

- Review and monitor the accounts receivable internal control structure to provide reasonable assurance that reported amounts and transactions are valid and documented.

- Establish an integrated financial management system for use by Medicare contractors and HCFA's central office to promote consistency and reliability in recording and reporting accounts receivable information.

- Modify the current policies for recognizing MSP accounts receivable to comply with applicable Federal accounting standards.

- Implement a process to identify and write-off MSP accounts receivable that are part of settlement agreements for MSP overpayments.

- Provide additional guidance to Medicare contractors to promote a uniform method for estimating the allowance for uncollectible accounts. Also, ensure that the estimated allowance for uncollectible accounts is based on historical data, which is available at each Medicare contractor's site and validated against information generated at HCFA's central office.

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- Enhance contractor billing and cash controls by emphasizing the importance of segregation of duties, reconciliation processes, and other cash control techniques.

- Ensure that all Medicare contractors develop control procedures to provide independent checks of the validity, accuracy, and completeness of the amounts reported to HCFA, including a reconciliation with the contractors' supporting documentation, and periodically review contractors' control procedures over the reconciliation.

- Ensure that Medicare contractors receive ongoing training on preparing HCFA 750/751 reports.

- Develop appropriate input/output controls for routinely reviewing the HCFA 750/751 and other reports received from Medicare contractors to identify unusual items and inconsistencies and emphasize HCFA's reliance on these reports.

- Revise reporting requirements to reflect HCFA's expectation of the need to retain support for significant accounts, in an auditable format, at each Medicare contractor site.

2. Financial Management Controls for Contractors and Preparation of HCFA Financial Reports *(Repeat Condition)*

The OMB Circular A-127 requires that financial statements be the culmination of a systematic accounting process. The statements are to result from an accounting system that is an integral part of a total financial management system containing sufficient structure, effective internal controls, and reliable data.

HCFA does not have an integrated accounting system to capture expenditures at the Medicare contractor level. HCFA relies on a complex system of reporting and ad hoc reports to accumulate data for financial reporting.

Our review of the internal control structure at selected Medicare contractors disclosed numerous weaknesses in their ability to report accurate financial information. These weaknesses may be partly due to the absence of certain components of a fully integrated financial management system, including full accrual accounting, a double-entry general ledger system, proper cut-off procedures, and adequate source documentation for Medicare Program activity. These weaknesses increase the risk of material misstatement in the financial statements. In addition, Medicare contractors do not utilize uniform accounting systems that record, classify, and summarize information for the preparation of financial statements. Moreover, as discussed below, HCFA's central office and regional offices

oversight of Medicare contractor operations and financial management controls has not provided reasonable assurance that material errors would be detected in a timely manner.

Financial Reporting and Reconciliations - Medicare Contractors

The reconciliation of "total funds expended" on the HCFA 1522, Monthly Contractor Financial Report is an important control which ensures that all amounts reported to HCFA by Medicare contractors are accurate, supported, complete, and properly classified. At the Medicare contractor level, "total funds expended" is the sum of all checks drawn and electronic fund transfer payments issued during the calendar month less voided checks and overpayment recoveries. This amount is then further classified by component into the following categories: benefit payments, PIP, accelerated payments, net suspense payments, audit reimbursement adjustments, and interest income and expenses. HCFA uses the information from this report to prepare its financial statements.

An essential part of the audit is a review of paid claims to determine if claims are paid in accordance with Medicare regulations and are for covered services. This reconciliation is critical because the auditors must be able to obtain a file of paid claims that will reconcile to the HCFA 1522 before selection of a statistically valid sample of claims is reviewed. As of May 1998, HCFA has mandated that all Medicare contractors prepare a monthly reconciliation of their prior months HCFA 1522 to adjudicated claims processed, to other payments, to overpayment recoveries and to other adjustments as necessary.

Our analysis of the HCFA 1522 reports at the 12 selected Medicare contractors identified the following similar internal control weaknesses as reported in our prior audit reports:

- At three of the 12 Medicare contractors, paid claim activity and "total funds expended" were not formally reconciled. It took several months for these contractors to produce payment tapes that reconciled with the monthly HCFA 1522 reports because adjusting entries were not identified and proper cutoff periods were not used.

- Four of the 12 Medicare contractors tested did not have internal policies or procedures for preparing the HCFA 1522.

- Only one of the 12 Medicare contractors tested had readily available general ledgers and appropriate subsidiary records to support all components of "total funds expended" on the HCFA 1522. In order to prepare the monthly HCFA 1522 reports, the other 11 Medicare contractors had to obtain data from various sources, such as the computerized claims processing system, bank statements, manually prepared documents and ledgers, and estimates.

- The HCFA 1522 was not subjected to independent verification at seven contractors.

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Financial Reporting - HCFA Central Office

HCFA's process for preparing annual financial statements is manually intensive and involves a series of spreadsheets which start with general ledger data adjusted to incorporate Treasury and Medicare contractor information. While HCFA's Financial Accounting Control System (FACS) is a dual-entry system, extensive adjustments are required to prepare the annual financial statements. This increases the risk that material errors may not be detected in a timely manner. In addition, HCFA's use of large spreadsheet programs to prepare its annual financial statements and supporting documentation is complicated and cumbersome and hinders HCFA's ability to prepare and have its statements audited timely.

Specifically, we found that:

- FACS does not capture all financial data reported by HCFA. For example, Treasury data reported to HCFA is entered directly into the spreadsheet programs used to prepare HCFA's financial statements and never recorded in FACS.

- Although HCFA has developed formally written policies and procedures for preparing, approving, or retaining journal entries; we could not obtain evidence that the policies and procedures were followed in preparing adjustments at year end.

- Numerous adjustments were required at year end to properly reflect accounts in the financial statements.

- Ad hoc spreadsheets are used to maintain HCFA's financial statement information.

Recommendations

To improve financial management controls and financial reporting, we recommend that HCFA:

- Ensure that all Medicare contractors develop control procedures to provide independent checks of the validity, accuracy, and completeness of the amounts reported to HCFA, including a reconciliation with the contractors' supporting documentation, and periodically review contractors' control procedures over reconciliations.

- Obtain an accounting software package which will automatically manipulate data for development of financial statements. Further, HCFA should develop

procedures to ensure an audit trail exists and approval of entries and assumptions are made.

- Continue efforts to promote uniformity and integration of Medicare contractors' systems.

- Include the issues relating to financial management discussed in this report and HCFA internal reviews of the FFMIA conformance of its systems in the DHHS FY 1999 FMFIA report.

3. Medicare Electronic Data Processing (EDP) Controls *(Repeat Condition)*

For FY 1998, HCFA relied on extensive data processing operations at both HCFA and contractors that process Medicare claims to administer the Medicare program and process and account for $210 billion in Medicare expenditures. HCFA's central office computer center primarily maintains administrative data, such as Medicare enrollment, eligibility, and paid claims data, but it also processes all payments for managed care.

Medicare contractors utilize one of several "shared" systems to process and pay Medicare fee-for-service claims. As part of fee-for-service claims processing, the "shared" systems interface with the Common Working File (CWF) to obtain authorization to pay claims. The CWF uses seven distributed databases to coordinate Medicare Part A and Part B benefits and approve claims for payment. The seven CWF databases are maintained by contractors referred to as CWF hosts. In addition, the "shared" systems and CWF are designed and maintained by separate contractors referred to as systems maintainers.

Our review of EDP internal controls was limited to general and application controls and did not include management or operations controls. Controls associated with the general data processing environment (general controls) are critical to ensuring the reliability, confidentiality, and availability of HCFA's data. These EDP general controls involve the entity-wide security program, access controls, application development and program change controls, segregation of duties, operating system software, and service continuity. The EDP general controls affect the integrity of all applications operating within a single data processing facility. The extent of our testing was impacted by resource constraints at HCFA's central office and certain contractors due to the need for system personnel to devote attention to resolving Year 2000 (Y2K) readiness issues. Had we performed testing as originally contemplated, additional matters specific to HCFA's central office or individual contractor systems or applications might have been identified.

Numerous EDP control weaknesses were found at selected Medicare contractors. Specifically, we found deficiencies in entity-wide security programs, access controls, application development and program change controls, segregation of duties, systems software, and service continuity. Additionally, the prior year material control issue and the majority of the reportable conditions at HCFA's central office are outstanding. Overall,

access controls, as well as shared systems application controls, are being reported as material weaknesses.

HCFA Computer Center Facility

We conducted a follow-up of the status of the prior year information technology (IT) findings and recommendations. Accordingly, we conducted several meetings and reviewed documentation, contracts, and correspondence to confirm the status of each individual finding and recommendation.

Overall, our high-level review of IT processes and controls did not disclose any new material control weakness for FY 1998. However, regarding the follow-up of the prior year findings and recommendations, we found that HCFA's central office had implemented several key initiatives to correct the prior control issues. Some of the notable accomplishments were:

- The creation of the Financial Management Investment Board (FMIB), staffed by deputy directors, that evaluates and approves IT investments at HCFA.

- The reengineering and empowerment of Configuration Management that is currently responsible for evaluation and certification of systems for Y2K readiness. This function is currently ensuring a "true production" state for HCFA's central office.

- The establishment of a technical review and approval process through an application and Change Control Board. The Board currently addresses Medicare standard systems, which includes the CWF and the Fiscal Intermediary Shared System (FISS) and is anticipated to expand into internal systems.

- The awarding of several task orders to various contractors to correct prior year issues related to risk assessment; upgrading security policies and procedures; verification, validation, evaluation and analysis of security systems; development of training plan and course materials to enhance systems security training.

Although the first three items above represent significant accomplishments in terms of the overall IT controls, the implementation of planned corrective actions for the majority of the issues is scheduled in 1999. Therefore, the prior year material weakness and the majority of the reportable conditions related to access controls, entity-wide security program, application development and program change controls, segregation of duties, and systems software remain unchanged. HCFA needs to continue implementing the planned corrective actions to fully address the prior year material weakness and reportable conditions at the central office.

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Medicare Contractors

We completed EDP reviews at a sample of 12 Medicare contractors for FY 1998. In addition, general controls reviews at CWF host sites and at the FISS maintainer were performed. The application controls of the FISS, Viable Information Processing System (VIPS), and CWF were assessed. More summarized assessments of EDP general controls at other sample contractors were performed.

We identified opportunities for enhancing information systems controls at 11 of the 12 Medicare contractors that we visited. We were able to penetrate the security systems and obtain access to sensitive Medicare data at five Medicare contractor locations. Unauthorized users may exploit this security weakness and confidential medical data may be disclosed. We noted material controls weaknesses in the FISS and CWF applications that could result in improper processing or inappropriate payment of Medicare claims. Specifically, we found that FISS edits can be deactivated or bypassed. For example, the 100 percent duplicate claims edits or reason codes can be deactivated or bypassed automatically through a forced code. We also noted paid FISS claims that bypassed CWF processing and that management review of the bypass process needs to be improved and formalized. Additionally, we found six potential duplicate claims in the FISS paid claims file. The claims were paid by a former Medicare contractor and the claims records were converted to the paid claims history files of the newly assigned contractor. Finally, we found instances at two contractors where duplicate claims had been paid and processed on the same day but had not been detected by the FISS duplicate edit.

We also found that several other material weaknesses in controls noted during the previous fiscal year remained unchanged as described in the following sentences. We previously reported that data centers had full access to the FISS source code and could perform local changes to FISS programs. This access may be abused resulting in unauthorized programs being implemented and executed at fiscal intermediaries and carrier data centers. Although HCFA now requires contractors to restrict local changes to emergency situations, the local changes are not subjected to the same controls that existed in the standard FISS change process. Additionally, last year's audit disclosed an override library that was developed by one data center to give priority to locally modified FISS programs. Consequently, the local programs always override the standard FISS programs provided by the maintainer. For the Multi-Carrier System (MCS), we previously reported that each individual carrier could deactivate HCFA mandated edits. These prior year material controls issues are still open.

As evidenced by the varied findings in 1998 at the Medicare contractors, HCFA did not have a consistent set of policies to oversee and review the effectiveness of general controls at its contractors. However, HCFA is currently developing and implementing policies and procedures that are scheduled for completion in 1999. HCFA had a program to contract EDP control assessments at selected contractors. This program was curtailed in FY 1998,

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although a high-level review of several aspects of enterprise and local area network security at several contractors was performed.

Recommendations

The Medicare program relies upon automated systems for the administration of virtually all aspects of the program. Accordingly, based on the significance of the weaknesses noted above, the need for improvements in EDP controls at the Medicare contractors and HCFA's central office are considered to be material weaknesses. Our detailed findings and recommendations have been communicated to OIG and HCFA's management.

For the central office EDP controls, we recommend that HCFA continue to implement cost effective improvements which will ensure that:

- An entity-wide security structure is implemented to achieve security program objectives.
- Access controls are adequate to protect data and other resources from unauthorized modification or destruction. Specifically, HCFA should complete the planned security enhancement project.
- Application development and program change control procedures protect against unauthorized changes.
- Assigned responsibilities adequately segregate computer related duties.
- Controls over system software integrity and changes properly restrict access to authorized personnel and protect against unauthorized changes.
- Service continuity plans are current and periodically tested.
- Material weaknesses associated with the HCFA central office and Medicare contractors in DHHS's FMFIA report are reported.
- HCFA continue with its process of evaluating EDP controls at the contractor level whereby all contractors are periodically assessed and all findings and recommendations are tracked through final implementation.

For the Medicare contractor EDP controls, we recommend that HCFA coordinate with contractors to ensure that:

- FISS changes are authorized, documented and tested to maintain the integrity of the application.

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- Override libraries are further examined to determine the necessity of their usage.
- A core set of FISS, MCS and CWF programs are defined and protected against local modifications.
- Claims are processed and approved by CWF prior to payment.
- Mandated edits within the FISS and MCS applications are not modified by contractors to ensure that the claims are processed in accordance with existing Medicare regulations.
- An entity-wide security structure is implemented to achieve security program objectives, and that access controls are adequate to protect data and other resources from unauthorized modification or destruction, application development and program change control procedures protect against unauthorized changes, assigned responsibilities adequately segregate computer related duties, controls over system software integrity and changes properly restrict access to authorized personnel and protects against unauthorized changes, and service continuity plans are current and periodically tested.

Reportable Conditions

1. HCFA Regional Office Oversight of Medicare *(Repeat Condition)*

HCFA's regional offices have oversight responsibility for Medicare contractors. A majority of the oversight efforts are conducted through the Contractor Performance Evaluation (CPE) review process. The purpose of CPE is to evaluate Medicare contractors' compliance with Medicare laws and regulations.

Contractors administer claims paid to providers, perform program safeguards activities, and prepare and submit periodic financial reports to HCFA that are used in the preparation of HCFA's financial statements. While we noted significant improvement in many of the Medicare oversight procedures performed by the regional offices during 1998, we found that certain procedures were not adequate or were not being performed consistently in all regions to ensure that financial data provided by contractors is reliable, accurate, and complete.

- Lack of procedures for monitoring Medicare contractors' Statements of Financial Position (HCFA 750) and Status of Accounts Receivable (HCFA 751) reports.
- Lack of procedures to monitor HCFA 1522 reports.

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- Insufficient frequency of conducting Audit Quality Review Program (AQRP) procedures.
- Lack of procedures to verify the completeness of the Provider Overpayment Report (POR) and the Physician Supplier Overpayment Report (PSOR).
- Lack of on-site review of Medicare contractor change management plans.
- Inadequate procedures, and inadequate documentation, of reviews of Medicare contractors' security systems.
- Inconsistent application of risk assessment procedures in allocating resources to reviews.

Recommendations

The following recommendations would greatly enhance the regional offices' oversight functions:

- Issue instructions that specify the expectations and the procedures to be performed by regional offices to ensure that HCFA 750/751 and HCFA 1522 reports are submitted timely and are properly reconciled to accounting records.
- Increase the frequency of the application of the Audit Quality Review Program to a larger Medicare contractor population which will encompass a greater number of providers.
- Ensure that Provider Overpayment Recovery and Physician Supplier Overpayment Recovery data are accurate, valid and complete for all Medicare contractors.
- Develop procedures to ensure that all change management plans are properly implemented by all Medicare contractors.
- Ensure that all regional offices are utilizing and documenting risk assessments of functions of contractors that impact the proper payment of claims and the financial reporting of provider data.

2. Medicare Entitlement Benefits Due and Payable *(Repeat Condition)*

Medicare entitlement benefits due and payable totaled $28.7 billion at September 30, 1998. These liabilities represent the cost of services provided to Medicare beneficiaries but not paid at the end of the fiscal year. HCFA has continued to make improvements in estimating this liability; however, additional improvements are needed. While data reliability concerns

identified in prior years were not present this year, current estimation procedures may not be adequate to detect errors in data used in future projections. Specifically, formal measures to determine the reasonableness of data used in each of the five key components of the liability should be developed, implemented, and documented.

Recommendations

Management should periodically analyze and review data to assess the reasonableness of their estimate of entitlement benefits due and payable. Specifically, we recommend that HCFA:

- Periodically validate the database to ensure the existence and completeness of test data.
- Use the results of the detailed claims testing to assess the reasonableness of the estimate for entitlement benefits due and payable.
- Reconcile data obtained from Medicare contractors as part of the quarterly HCFA 1522 reporting process to other HCFA cost settlement data reports.
- Assess the availability of insurance industry and provider data to establish benchmarks and use this information to assess the reasonableness of the estimate for entitlement benefits due and payable.
- Reconcile its estimate to the National Claims History File monthly processing reports.
- Perform a trend analysis of the accounts payable estimate to expenditure history.
- Periodically validate key contractor provided information.

3. Lack of Reconciliation for (1) Medicaid Advances to Expenses and (2) Medicaid Expenses Recorded on Differing Reports

Other auditors, as referred to in the first paragraph of this report, reviewed procedures performed by HCFA at the regional offices to determine (1) whether Medicaid expenses as reported by the States are reconciled to funds advanced to the States, and (2) whether discrepancies that may exist between differing reports of Medicaid expenses are explained through a reconciliation process. They determined that no such reconciliations are performed by HCFA, that many States do not perform this reconciliation, and there is no requirement in the Compliance Supplement to the Single Audit Act for the State auditors to review a reconciliation.

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HCFA utilizes the DHHS/PSC/FMS/DPM's Payment Management System (PMS) to control payments to the States. The PMS electronically disburses Medicaid funds to the States, and on a monthly basis, informs HCFA of the funds advanced. The other auditors reviewed HCFA's regional office procedures for two quarterly Federal reports prepared for the Medicaid funding: (1) the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form HCFA 64) which shows the disposition of Medicaid grant funds (advances) for the quarter being reported, net of recoveries. The preparation of Form 64 is a requirement of the States and is submitted to HCFA; and (2) the Federal Cash Transactions Report, Status of Federal Funds (PMS 272), which makes known to States the total cash made available (advances) for the quarter. States are required to review the PMS 272 and report the results of reconciling the advances indicated on the PMS 272 with the States' records. The States are also required to report the amounts disbursed for expenses, including amounts for the Medicaid program, for the quarter to the PMS system.

HCFA has not established procedures to ensure (1) that expenditures reported for the Medicaid program are reconciled to the funds advanced to States, and (2) that discrepancies between expenses on the HCFA 64 and PMS 272 are explained through a reconciliation process. This condition increases the risk that transactions related to the Medicaid appropriation have not been properly recorded and that misappropriation of funds could go undetected. The FMFIA establishes specific requirements with regard to management controls. HCFA must establish controls that reasonably ensure that (1) obligations and costs comply with applicable law; (2) assets are safeguarded against waste, loss, unauthorized use or misappropriation; and, (3) revenues and expenditures are properly recorded and accounted for.

HCFA is not able to perform reconciliations between the HCFA 64 and the PMS 272 as it does not have the detailed information which is available at the State level. Visits to a sample of States to review the audit procedures performed under the Single Audit Act revealed that while the information is readily available at the State level to perform the reconciliation, some States perform this reconciliation but many States do not.

Recommendations

- HCFA's regional offices should explore requiring each State to submit a quarterly reconciliation that identifies any differences between cash advances and expenditures per the PMS 272 to expenditures per the HCFA 64. All reconciling items should be reviewed for appropriateness and any differences should be identified and resolved.

- The Cash Management Improvement Act requires that the timing and amount of cash advances shall be as close as administratively feasible to the actual disbursements by the recipient organization for direct program costs and indirect costs. Requiring a reconciliation between the PMS 272 and the HCFA 64

would provide an additional benefit by enhancing HCFA's internal controls relating to the cash management area.

- HCFA's management should support a request to OMB for an amendment to the A-133 Compliance Supplement which would require the State auditors to verify that the States have reconciled reported expenditures on the HCFA 64 to the PMS 272.

4. HCFA Regional Office Oversight of Medicaid *(Repeat Condition)*

Many Medicaid oversight procedures relating to program expenditures, previously performed by the regional offices, have been significantly reduced or eliminated which increases the risk that inappropriate claims could be paid.

Visits during 1998 to regional offices and the examination of sample data selected from each region disclosed that weaknesses identified in prior years' audits were not corrected. Specifically, the other auditors' work in FY 1998 has disclosed the following conditions:

- Significantly reduced emphasis on detecting Medicaid errors and irregularities and on requiring States to devote resources to fraud and abuse collection activity.
- Insufficient review of disproportionate share payments.
- Lack of consistency between regional offices in extent of procedures performed in financial management reviews.
- Failure to implement procedures to compensate for loss of controls over the ongoing claims processing and reporting systems.
- Lack of consistency between regional offices in review of HCFA 64.
- Inadequate cash management review.

Recommendations

One of the primary responsibilities of the regional offices is to ensure that the States submit timely, accurate expenditure reports and pay claims in accordance with Medicaid laws and regulations. This oversight is accomplished through examination of the quarterly HCFA 64 reports and their supporting documentation, through financial management reviews of specific programs or types of expenditures, through reviews of State claims processing and reporting systems, and through ongoing communications and instructions to the States.

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The following recommendations would strengthen internal controls in this area:

- Review the HCFA 64 review process to ensure that procedures are in place to document a risk assessment process to provide assurance that prior reviews, prior findings, findings noted in other States for similar conditions, the incidence of new programs and other pertinent factors are considered. Resource needs should be studied to facilitate the performance of comprehensive reviews.

- Develop a documented risk assessment process to determine the need to perform reviews of disproportionate share payments to provide a level of assurance that payments are properly being made to providers only for uncompensated patient care.

- Study the financial management review processes and procedures currently in place at all of the regional offices to determine a "best practices" approach. Based on this study, guidelines should be issued to provide for the appropriate identification of issues for review and for instructions to promote consistency to the "best practices" approach between regions.

- Develop uniform procedures to ensure that States are sufficiently examining and evaluating the accuracy of claims processing and reporting systems.

- Review the quarterly PMS 272 submitted by the States to ensure that reported balances agree, that excessive cash on hand balances are not maintained, and the causes of reporting differences are identified and corrected where necessary.

5. Medicaid Claims Estimated Improper Payments

HCFA lacks sufficient methodology for estimating the range of improper Medicaid payments on a national level. Review of Medicare claims in recent years have determined that the majority of improper payments are the result of (1) insufficient or no documentation, (2) lack of medical necessity, (3) incorrect coding, and (4) non-covered or unallowable services. The results of this sampling provide HCFA with useful information in helping to reduce the overall Medicare improper payments. With no similar methodology in place for the Medicaid Program, HCFA is unable to draw any conclusions at a national level on improper Medicaid payments. Since Medicaid is a grant program, any sampling would need to be done in conjunction with the States.

Recommendation

We recommend that HCFA work with the States to develop procedures to implement a methodology to determine the range of improper payments in the Medicaid Program and continue its emphasis on reducing inappropriate claims payments for Medicaid.

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Status of Prior Year Comments

National Compliance-Medicare Fee for Service Error Rate

In addition to the comments discussed above, a comment entitled Monitoring National Compliance-Medicare Fee-For-Service Error Rate was included in last year's report on the internal control as a material weakness. The comment focused on the need to develop a routine process for estimating the extent of errors in payments for Medicare claims, and emphasized the need to continue efforts to reduce the incidence of inappropriate or unsupported payments. Accomplishments during FY 1998 included the development of a preliminary estimate of the range of possible inappropriate payments for cost report settlements, and the agreement by HCFA and the OIG to continue the systematic development of national error rates for Medicare claims, incorporating the OIG error rate development methodology into the tools which HCFA uses to monitor inappropriate payments.

In connection with development of the FY 1998 error rate, the OIG (A-17-99-00099) updated certain of the recommendations made in last year's report, as repeated below. HCFA's management is in the process of implementing these recommendations, with HCFA's emphasis on fraud and abuse initiatives, development of a redesigned claims processing organization incorporating program safeguard operations in specialized units, and ongoing revisions to claims processing procedures and systems planned for 1999 and beyond. This comment has been classified as partially complete and is reported as an other matter impacting HCFA's internal control.

Recommendations

- Continue to update systems' capabilities to keep pace with questionable billing practices.
- Ensure that adequate program safeguards are in place for those Medicare contractors that transition out of the Medicare program.
- Enhance prepayment and post-payment controls by updating computer systems and related software technology to better detect improper Medicare claims.
- Continue to direct that Medicare contractors expand provider training to further emphasize the need to maintain medical records that contain sufficient documentation as well as to use proper procedure codes when billing Medicare for services provided.

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- Direct its Provider Review Organizations to identify high-risk areas and reinstate selected surveillance initiatives, such as hospital readmission review and Diagnostic Related Group (DRG) coding reviews.

- Continue to refine Medicare regulations and guidelines to provide the best possible assurance that medical procedures and services are correctly coded and sufficiently documented.

- Continue to encourage health care providers and Medicare contractors to adopt compliance plans which promote adherence to applicable Federal program requirements and laws.

Federal Share of Medicaid Accounts Payable and Accounts Receivable

In addition, a comment regarding the federal share of Medicaid Accounts Payable and Accounts Receivable was included as a reportable condition in 1997. Survey information on the Federal share of accounts receivable received by HCFA in prior years was limited and difficult to accurately use in estimating the total Federal share of accounts payable and accounts receivable. HCFA worked with the States to increase the response rate and the quality of information provided in FY 1998. This, coupled with the accumulation of several years of historical data facilitated analytical reviews of these estimates. Accordingly, this matter has been reported as an other matter in 1998. Other auditors recommend that HCFA continue its annual survey process or find a suitable alternative to estimate the net accounts payable amount. Trend data of accounts receivable and accounts payable over time should be developed for each State and used to improve and further refine the estimation model.

A separate letter, dated January 29, 1999, was provided to management which discusses other internal control matters which came to our attention as a result of our audit.

This letter is intended for the use of the management of HCFA and the Office of Inspector General, Department of Health and Human Services and the Office of Management and Budget, and is not intended to be and should not be used by anyone other than these specified parties.

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January 29, 1999

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Report of Independent Auditors on Compliance with Laws and Regulations

To the Inspector General of the
Department of Health and Human Services
and the Administrator of the Health Care Financing Administration

We have audited the consolidated balance sheet of the Health Care Financing Administration (HCFA) as of September 30, 1998, the related consolidated statements of net cost and changes in net position and combined statements of budgetary resources and financing for the year then ended. The Medicaid Program, a major HCFA administered program, had total assets of $11.7 billion as of September 30, 1998 and total net costs of $97.9 billion for the year then ended. The Medicaid Program financial information, which is included in HCFA's consolidated and combined financial statements, was audited by other auditors whose report has been furnished to us, and our opinion, insofar as it relates to Medicaid financial information, is based solely on the report of the other auditors. Our report, dated January 29, 1999, on HCFA's consolidated and combined financial statements was qualified for the effects of such adjustments, if any, that might have been determined to be necessary had we been able to examine evidence supporting the Medicare accounts receivable and related activity as of, and for the year ended, September 30, 1998.

Except for the matters discussed in the third paragraph of our report on the financial statements, we conducted our audit in accordance with generally accepted auditing standards; *Government Auditing Standards*, issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 98-08, *Audit Requirements for Federal Financial Statements* (as amended).

The management of HCFA is responsible for complying with laws and regulations applicable to HCFA. As part of obtaining reasonable assurance about whether HCFA's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws and regulations, noncompliance with which could have a direct and material effect on the determination of financial statement amounts and certain other laws and regulations specified in OMB Bulletin 98-08, including the requirements referred to in the Federal Financial Management Improvement Act (FFMIA) of 1996.

Material instances of noncompliance are failures to follow applicable laws and regulations to the extent that the effects of such noncompliance, in the aggregate, cause the financial statements to be misstated. The Department of Health Human Services (DHHS) Office of Inspector General (OIG) report entitled, "Improper Fiscal Year 1998 Medicare Fee-for-Service Payments" (A-17-99-00099 dated February 9, 1999) made an independent assessment of the extent of improper payments in the Medicare program. This review noted that of 5,540 claims valued at $5.6 million, 915 did not comply with Medicare laws and regulations. Based on the OIG's statistically valid sample, they estimated that improper Medicare benefit payments made during FY 1998 totaled $12.6 billion, or about 7.1 percent of the $176.1 billion in processed fee-for-service payments reported by HCFA. This estimate is $7.7 billion less than last year's estimate of $20.3 billion and $10.6 billion less

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than the previous year's estimate of $23.2 billion. These improper payments, as with past years, could range from inadvertent mistakes to outright fraud and abuse. The OIG could not quantify what portion of the error rate is attributable to fraud. The overwhelming majority (90 percent) of the improper payments were detected through medical record reviews coordinated by the OIG. When these claims were submitted for payment to Medicare contractors, they contained no visible errors.

The results of our tests of compliance disclosed no instances of noncompliance with other laws and regulations discussed in the preceding paragraph exclusive of FFMIA that are required to be reported under Government Auditing Standards and OMB Bulletin 98-08.

At the request of the Office of Inspector General, Department of Health and Human Services, we performed tests of compliance to determine whether HCFA's financial management systems substantially comply with the Federal financial management systems requirements, applicable accounting standards, and the United States Standard General Ledger at the transaction level. To meet this requirement, we performed tests of compliance using the implementation guidance for the FFMIA included in Appendix D of OMB Bulletin 98-08.

The results of our tests disclosed instances where HCFA's financial management systems did not substantially comply with certain requirements discussed in the preceding paragraph. The following instances of noncompliance have been identified:

- HCFA does not have an integrated accounting system to capture expenditures at the Medicare contractor level, and certain aspects of the existing financial reporting system do not conform to the requirements currently specified by the Joint Financial Management Improvement Program.

- HCFA's process for preparing annual financial statements is manually intensive, involving a series of spreadsheets that incorporate general ledger data as well as Treasury information, contractor information, and adjustments determined by HCFA.

- HCFA recognizes accounts receivable prior to meeting all the criteria required by Statement of Federal Financial Accounting Standard (SFFAS) No. 1, *Accounting for Selected Assets and Liabilities* and SFFAS No. 7, *Accounting for Revenue and Other Financing Sources and Concept for Reconciling Budgetary and Financial Accounting,* potentially overstating reported accounts receivable.

- HCFA's central office and Medicare contractor access and application control weaknesses are significant departures from requirements in OMB Circulars, A-127, *Financial Management Systems*, and A-130, *Management of Federal Information Resources*.

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- The review of the DHHS central payroll system, performed by other independent auditors, identified three weaknesses that resulted in an assessment that central payroll is not A-127 compliant.

The Report of Independent Auditors on Internal Control and our separate management letter include information related to the financial management systems that were found not to comply with the requirements, relevant facts pertaining to the noncompliance, and our recommendations related to the specific issues presented. It is our understanding that management agrees with the facts as presented, and that relevant comments from HCFA management responsible for addressing the noncompliance have been incorporated into HCFA's discussion of the auditors' opinion.

Providing an opinion on compliance with certain provisions of laws and regulations was not an objective of our audit and, accordingly, we do not express such an opinion.

This report is intended for the use of the management of HCFA, the Office of the Inspector General, Department of Health and Human Services, and the OMB, and is not intended to be and should not be used by anyone other than these specified parties.

Ernst & Young LLP

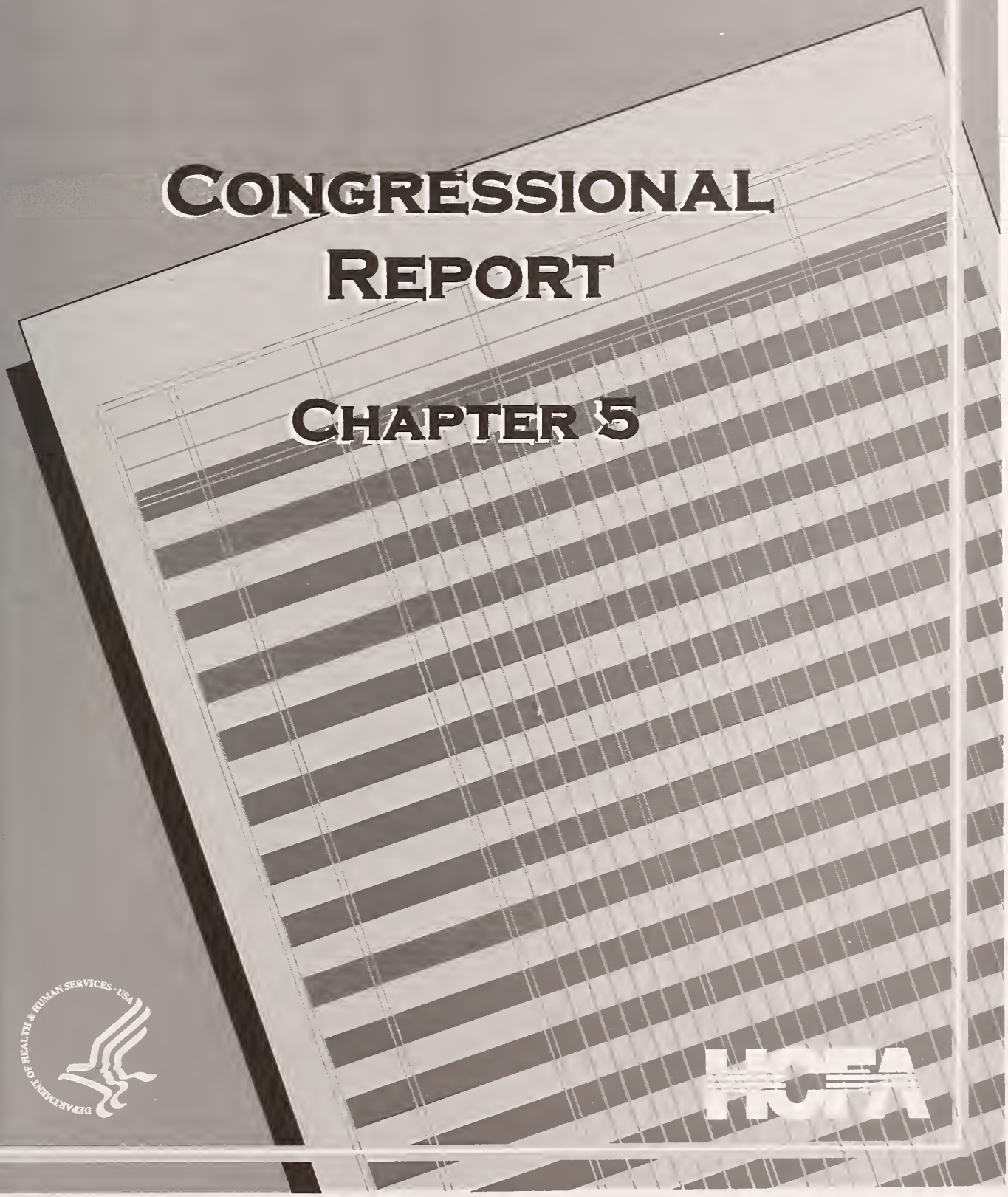
January 29, 1999

U.S. Department of Health and Human Services

Health Care Financing Administration

Congressional Report

Chapter 5



Congressional Reports

Medicare's Validation Program for Hospitals Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) 1997 Report

Introduction

Section 1865 of the Social Security Act (the Act) provides that JCAHO-accredited hospitals are deemed to meet the Medicare conditions of participation (CoPs). These hospitals are not subject to routine State surveys to assess compliance with the Medicare CoPs. Subsection 1864(c) of the Act, however, authorizes the Secretary to enter into an agreement with any State to survey hospitals accredited by the JCAHO on a selective sample basis[1] or in response to allegations of significant deficiencies that affect the health and safety of patients. The Act further requires, at Section 1875, that the Secretary include an evaluation of the JCAHO accreditation process for hospitals in an annual report to Congress. This evaluation is referred to as the validation program.

The purpose of the validation program is to determine whether the JCAHO's accreditation process provides reasonable assurance that accredited hospitals comply with the statutory requirements at section 1861(e) of the Act for participation in the Medicare program as hospitals. Each year, the Health Care Financing Administration (HCFA) selects approximately 5 percent of the JCAHO-accredited hospitals to be surveyed. The number actually surveyed is dependent on available survey resources.

Sample validation surveys fall into three categories. They are:

1. Random sample (hospitals randomly selected for survey within 60 days after the JCAHO survey);
2. 18-month sample (hospitals randomly selected for survey at the midpoint of their 3-year JCAHO accreditation cycle); and
3. Conditional sample (hospitals surveyed for selective Medicare requirements, based on JCAHO findings that caused the JCAHO to render an accreditation decision of conditional).

1. HCFA recently identified opportunities to improve the validation survey sampling process. Beginning in calendar year 1998, the sample will be drawn year-round using a systematic random sampling methodology. A work group is developing selection criteria to further improve hospital selection, given the limited resources available to conduct validation surveys.

In addition to the validation surveys, HCFA conducts substantial allegation (complaint) surveys of JCAHO-accredited hospitals in response to incoming complaints involving potential threats to the health and safety of patients.[2]

The JCAHO accreditation survey assesses a hospital's compliance with the JCAHO's standards. After completion of the on-site survey, the JCAHO makes an accreditation decision. The accreditation decisions include: accreditation, accreditation with Type I recommendations, conditional accreditation, and no accreditation.[3] Accreditation means that the hospital meets all JCAHO standards and requirements. Accreditation with Type I recommendations means that the hospital is granted accreditation with the assurance that the identified recommendations for improvement are implemented. The JCAHO requires hospitals with Type I recommendations to submit a written progress report or undergo a follow up survey. Conditional accreditation means that the hospital is in substantial noncompliance with JCAHO standards. Table 1 summarizes the JCAHO's accreditation decisions for Medicare-approved hospitals receiving a triennial survey in calendar years 1996 and 1997.

Table 1. JCAHO Accreditation Decisions, Medicare-Approved Hospitals Surveyed in 1996 and 1997

Accreditation Decisions	No. Hospitals in 1996 (Percent)	No. Hospitals in 1997 (Percent)
Accreditation	307 (18.8)	56 (14)
Accreditation With Type I Recommendations	1,335 (80.6)	1,308 (84)
Conditional	12 (0.7)	6 (2.1)
Total Surveyed [4]	1,656 (100)	1564 (100)

[2]. HCFA evaluates each complaint. If HCFA believes that the hospital would have a CoP out of compliance, the Agency authorizes the State to conduct a substantial allegation survey.

[3] JCAHO accreditation decisions also include commendation, preliminary nonaccreditation, and provisional accreditation. [HCFA does not recognize provisional accreditation for deeming.] The JCAHO considers all hospitals to be 'accredited' except those that are not accredited, including preliminary nonaccreditation. HCFA currently accepts the JCAHO definition of 'accredited' for deeming purposes.

[4] Categories do not sum to total because table does not include all accreditation categories.

Validation Survey Findings

Table 2 presents the number of random, 18-month, and conditional surveys HCFA performed, along with the compliance determinations (i.e., if the results of a validation survey showed noncompliance with one or more CoPs, the hospital was 'out of compliance'). A hospital may have had deficiencies of a lesser severity (e.g., standard level) and still be considered in compliance. This table also includes a comparison of the compliance pattern between validation surveys of accredited hospitals and routine surveys of nonaccredited hospitals.

Table 2. Compliance Determinations of Validation and Nonaccredited Hospital Surveys, 1997

	Number Out of Compliance	Percent	Total
Random Validation	13	16	79
18-Month Validation	2	100	2 [5]
Conditional Validation	0	0	0 [5]
All Validations	15	12	81
Nonaccredited	32	18	181

Table 3 presents the percent of JCAHO-accredited hospitals found out of compliance[6] by category of validation survey for the years, 1994 through 1997.

Table 3. Validation Survey Noncompliance by Category of Survey, 1994 Through 1997

	1994	1995	1996	1997
	Percent Out of Compliance			
Random	23	28	18	16
18-Month	26	10	31	100
Conditional	8	29	0	NA [5]

[5] Small or non-existant sample. There were only two hospitals surveyed midway in their triennial accreditation cycles and each had one or more conditions out of compliance. None of the JCAHO conditionally accredited hospitals were selected for validation surveys in 1997.

[6] Any accredited hospital found out of compliance with one or more CoPs loses its deemed stature reverting back to State jurisdiction. Deemed status is restored once the hospital is back in compliance.

Deficiency data were analyzed for 20 of 21 Medicare hospital CoPs:[7]

Federal, State, and Local Laws		Services	
Governing Body	Nursing	Anesthesia	RespiratoryCare
Medical Staff	Pharmaceutical	Rehabilitative	Emergency
Infection Control	Laboratory	Food & Dietetic	Outpatient
Quality Assurance	Medical Records	Surgical	NuclearMedicine
Discharge Planning	Physical Environment	Radiologic	

The three general health and safety CoPs found out of compliance most frequently for the 79 validation surveys performed in 1997 are shown in Table 4. The three CoPs found out of compliance most frequently for the 181 nonaccredited hospitals surveyed in 1997 are shown for comparison.

Table 4. Most Frequently Cited Conditions of Participation During Surveys, 1997

Accredited Hospitals		Frequency		Nonaccredited Hospitals	Frequency
1	Physical Environment Life Safety Code	13	1	Quality Assurance	7.00
2	Food & Dietetic	1	2	Infection Control	4.00
3	Pharmaceutical Services	1	3	Physical Environment	3.96

JCAHO Survey Process for Life Safety Code (LSC)

Since 1995, the JCAHO has been evaluating hospital compliance with LSC by having the hospital assess its own compliance and record the findings and plans for correction on the JCAHO Statement of Conditions (SoC) document. If a JCAHO surveyor identifies a LSC deficiency that has not been self-reported on the SoC by the hospital, it is 'scored' (i.e., it becomes a recommendation on the accreditation report). A self-assessed deficiency is not scored and reported on the Accreditation Report unless the surveyor determines that the hospital is making little or no progress in correcting that deficiency. HCFA surveys do not include a self-assessment by the hospital. Any deficiencies noted by State surveyors are included on the Federal Form HCFA-2567, Statement of Deficiencies and Plan of Correction. Although taken into account in this report, at the present time comparison of specific LSC

[7] The CoP not analyzed was Utilization Review. Accredited hospitals do not receive deemed status for this CoP.

deficiencies found using the JCAHO self-assessment and the HCFA survey process is difficult. Based on feedback and suggestions from HCFA, JCAHO is developing a reporting format that will facilitate the comparison of the data, and allow HCFA to evaluate the efficacy of the JCAHO LSC self-assessment.

Allegation Surveys

In 1997, 1,771 allegation surveys of JCAHO-accredited hospitals were conducted with 29 found out of compliance with one or more CoPs. Also, 300 allegation surveys of Non-accredited Hospitals were conducted with 16 found out of compliance with one or more CoPs. Table 5 summarizes the most frequently cited CoPs.

Table 5. Most Frequently Cited Conditions of Participation, During Allegation Surveys, 1997

Accredited Hospitals		Nonaccredited Hospitals	
Condition Not Met	Frequency	Condition Not Met	Frequency
Quality Assurance	12	Quality Assurance	5
Governing Body	5	Governing Body	3
Compliance with Federal/State/Local Laws	3	Nursing Services Emergency Services	2 2

Rate of Disparity

As set forth in regulation at 42 CFR 488.8(d)(2)(l), following the end of a validation review period, HCFA will identify any accreditation program for which validation survey results indicate a 20 percent or more rate of disparity between the findings of the accreditation organization and the State agency. Accreditation programs with a disparity rate of 20 percent or more will be subject to a deeming authority review to determine if that organization has indeed adopted and maintained requirements comparable to HCFA's. Of the 79 JCAHO validation surveys performed in 1997, 14 showed condition-level noncompliance. Comparing the survey reports of these hospitals with the corresponding JCAHO accreditation reports, 8 showed comparable condition-level deficiencies. This equals a disparity rate of 10 percent (which is below HCFA's cutoff point of 20 percent).

Changing the Evaluation Methodology and Future Plans for Validation

The current validation program has received much criticism over the years. It is difficult to draw conclusions about the above-mentioned disparity rate because the State and JCAHO

evaluate at different points in time. In response to such criticism, HCFA initiated a project in 1994 to reinvent the way it evaluates accreditation organizations approved by HCFA, (e.g., the JCAHO hospital accreditation program). The new evaluation program will be comprehensive and systematic, looking at a program's pre-survey, intra-survey, and post-survey activities. The Accredited Hospital Reinvention Project included a pilot in which a HCFA Evaluation Team observed JCAHO survey teams during 20 triennial surveys.

Report on Validation Surveys of Accredited Laboratories for FY 1997 Under the Clinical Laboratory Improvement Amendments of 1988

Introduction

This report covers the evaluation of the performance during fiscal year 1997 of the six accreditation organizations approved under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). The six approved organizations are the:

- American Association of Blood Banks (AABB)
- American Osteopathic Association (AOA)
- American Society of Histocompatability and Immunogenetics (ASHI)
- College of American Pathologists (College)
- Commission on Office Laboratory Accreditation (COLA)
- Joint Commission on Accreditation of Healthcare Organizations (Joint Commission)

We appreciate the cooperation of all of the organizations in providing their inspection schedules and results. While an annual performance evaluation of each approved accreditation organization is required by statute, we see this as an opportunity to present information about, and dialogue with, each organization in our mutual interest in improving the quality of testing performed by clinical laboratories across the nation.

Legislative Authority and Mandate

Section 353 of the Public Health Service Act, as amended by the Clinical Laboratory Improvement Amendments of 1988 (CLIA), requires any laboratory that performs testing on human specimens to meet the requirements established by the Department of Health and Human Services (HHS) and have in effect an appropriate certificate. Section 353 further provides that a laboratory meeting the standards of an approved accrediting body may obtain a CLIA Certificate of Accreditation. Under the CLIA Certificate of Accreditation, the laboratory is not routinely subject to direct federal oversight by HCFA. Instead, the laboratory receives an inspection by the accrediting body in the course of maintaining its accreditation,

and by virtue of this accreditation, is "deemed" to meet the CLIA requirements. The CLIA requirements pertain to quality assurance and quality control programs, records, equipment, personnel, proficiency testing and others to assure accurate and reliable laboratory examinations and procedures.

In section 353(e)(2)(D), the Secretary is required to evaluate each approved accrediting body by inspecting a sample of the laboratories they accredit. In addition, section 353(e)(3), requires the Secretary to submit to Congress an annual report on the results of the evaluation. This report is submitted to satisfy this requirement.

Regulations implementing Section 353 are contained in 42CFR Part 493 Laboratory Requirements. Subpart E contains the requirements for validation inspections conducted by HCFA or its agent, to ascertain whether the laboratory is in compliance with the applicable CLIA requirements. Validation inspections are conducted no more than 60 days after the accreditation organization's inspection, on a representative sample basis or in response to a complaint. The results of these validation inspections or "surveys" provide:

- on a laboratory-specific basis, insight into the effectiveness of the accreditation organization's standards and accreditation process; and

- in the aggregate, an indication of the organization's capability to assure laboratory performance equal to or more stringent than that required by CLIA.

The CLIA regulations, at 42CFR Part 493, Subpart E, section 493.511, provide that if the validation survey results over a one-year period indicate a rate of disparity of 20 percent or more between the findings in the accreditation organization's results and the condition-level [8] findings of the CLIA validation surveys, HCFA can re-evaluate whether the accreditation organization continues to meet the criteria for being granted deeming authority. Section 493.511 provides that HCFA also has the discretion to review deeming authority for an accreditation organization if the validation findings indicate such widespread or systematic problems that the organization's requirements are no longer equivalent to CLIA requirements.

[8] A condition-level requirement pertains to the significant, comprehensive requirements of CLIA, as opposed to a standard-level requirement, which is more detailed, more specific. A condition-level deficiency is an inadequacy in the laboratory's quality of services that adversely affects, or has the potential to adversely affect, the accuracy and reliability of patient test results.

Validation Reviews

The validation review methodology focuses on the actual implementation of the accreditation organization's standards described in its request for deeming authority under CLIA. Those standards were approved by HCFA as being equivalent to, or more stringent than, the CLIA requirements. The equivalency is the basis for granting deeming authority.

For each laboratory in the validation survey sample, any findings from the CLIA validation survey that result in deficiencies at the condition level are evaluated with the accreditation organization's inspection results to determine comparability. If HCFA concludes that one or more of those deficiencies was present in the laboratory's operations at the time of the accreditation organization's inspection, yet their inspection results did not note them, the case is a disparity. When all the cases in the sample have been reviewed, the "rate of disparity" for each organization is calculated by dividing the number of disparate cases by the total number of validation surveys for each organization.

Number of Validation Surveys Performed

The number of validation surveys is sufficient to "allow a reasonable estimate of the performance"of each accreditation organization, as indicated in the CLIA statute.

A representative sample of the more than 14,000 accredited laboratories received a validation survey in FY 97. Fewer than 400 laboratories used AABB, AOA, or ASHI accreditation for CLIA purposes. Given these proportions, very few validation surveys were performed in AABB, AOA and ASHI-accredited laboratories. The overwhelming majority of accredited labs in the CLIA program used the other three organizations--the College, COLA or the Joint Commission. The number performed for the other three organizations was proportionate to each organization's representation in the total accredited laboratory universe.

Results of the Validation Reviews of Each Accreditation Organization

American Association of Blood Banks
Rate of disparity: No disparity

Approximately 200 laboratories used their AABB accrerditation for CLIA purposes. Five validation surveys were conducted at AABB-accredited laboratories. No condition-level deficiencies were cited on any of the validation surveys.

American Osteopathic Association
Rate of disparity: No disparity

For CLIA purposes, approximately 40 laboratories used their AOA accreditation. Two validation surveys were considered reasonable to evaluate this organization's performance. No condition-level deficienties were cited on either validation surveys.

American Society of Histocompatability and Immunogenetics
Rate of Disparity: No disparity

About 40 laboratories used their ASHI accreditation for CLIA purposes. Two validation surveys were considered reasonable for this evaluation. No condition-level deficiencies were cited on either validation survey.

College of American Pathologists
Rate of disparity: 1%

A total of 75 validation surveys were conducted at laboratories accredited by the College. One survey was eliminated from the review due to an administrative issue. Of the remaining 74 cases, only one laboratory was cited with condition-level deficiencies. Comparable deficiencies were not cited, however, by the College's inspection.

Following is the laboratory identification number and the location of the laboratory that had disparate findings by the College, along with the CLIA condition-level requirements cited on the validation survey.

CLIA number	Location	CLIA Conditions
04D0891911	Arkansas	Patient Test Management Quality Assurance

Commission on Office Laboratory Accreditation
Rate of disparity: 9%

Validation surveys were conducted at 111 laboratories accredited by COLA. Three of those surveys were eliminated from the review because they were performed untimely for validation purposes. Of the remaining cases 14 laboratories were cited with CLIA condition-level deficiencies. Comparable deficiencies were not cited by COLA in 10 of those 14 laboratories.

Following is a listing of the CLIA identification number and location of the laboratories that had disparate inspection results by COLA, along with the CLIA condition-level requirements cited on the validation surveys.

CLIA number	Location	CLIA Conditions
05D0718637	California	General Quality Control (QC)
		Laboratory Director
05D0603607	California	QC - Bacteriology
		Laboratory Director
		Technical Supervisor
10D0293299	Florida	Proficiency Testing(PT) Enrollment
23D0368671	Michigan	PT-Specialty of Chemistry
23D0869326	Michigan	Hematology
		General QC
		General Immunology
		Routine Chemistry
		QC-Endocrinolgy
		Quality Assurance
23D0377327	Michigan	Quality Assurance
23D0694065	Missouri	PT Enrollment
33D0669680	New York	PT Enrollment
36D0336921	Ohio	PT Enrollment
		QC-Bacteriology
		Laboratory Director
		Quality Assurance
36D0890424	Ohio	PT Enrollment
		QC-Urinalysis
		Urinalysis
		Labortory Director
		Quality Assurance

Joint Commission on Accreditation of Healthcare Organizations
Rate of disparity: 5%

During this validation period, 56 validation surveys were conducted at laboratories accredited by the Joint Commission. One survey was eliminated from the comparison because the CLIA survey was performed untimely for validation purposes. On the remaining 55 cases receiving a comparative review, five laboratories were cited with CLIA condition-level deficiencies. Comparable deficiencies were not cited by the Joint Commission in three of those cases.

Following is a listing of the laboratory identification number and location of each laboratory that had disparate Joint Commission inspection findings, along with the CLIA condition-level requirements cited on the validation survey.

CLIA number	Location	CLIA Conditions
14D0421614	Illinois	PT Enrollment
		QC-Cytology
16D0384753	Iowa	PT Enrollment
45D0712300	Texas	Laboratory Director
		Quality Assurance

Conclusion

The findings of the validation review for 1997 indicate that all of the approved accreditation organizations approved performed at a level well below the 20 percent threshold that would trigger a deeming authority review. The rates of disparity ranged from no disparity to 9 percent. Moreover, the validation review did not reveal widespread or systematic problems of such serious nature that would cause the continuing equivalency of any of the organization's requirements, as a whole, to be questioned.

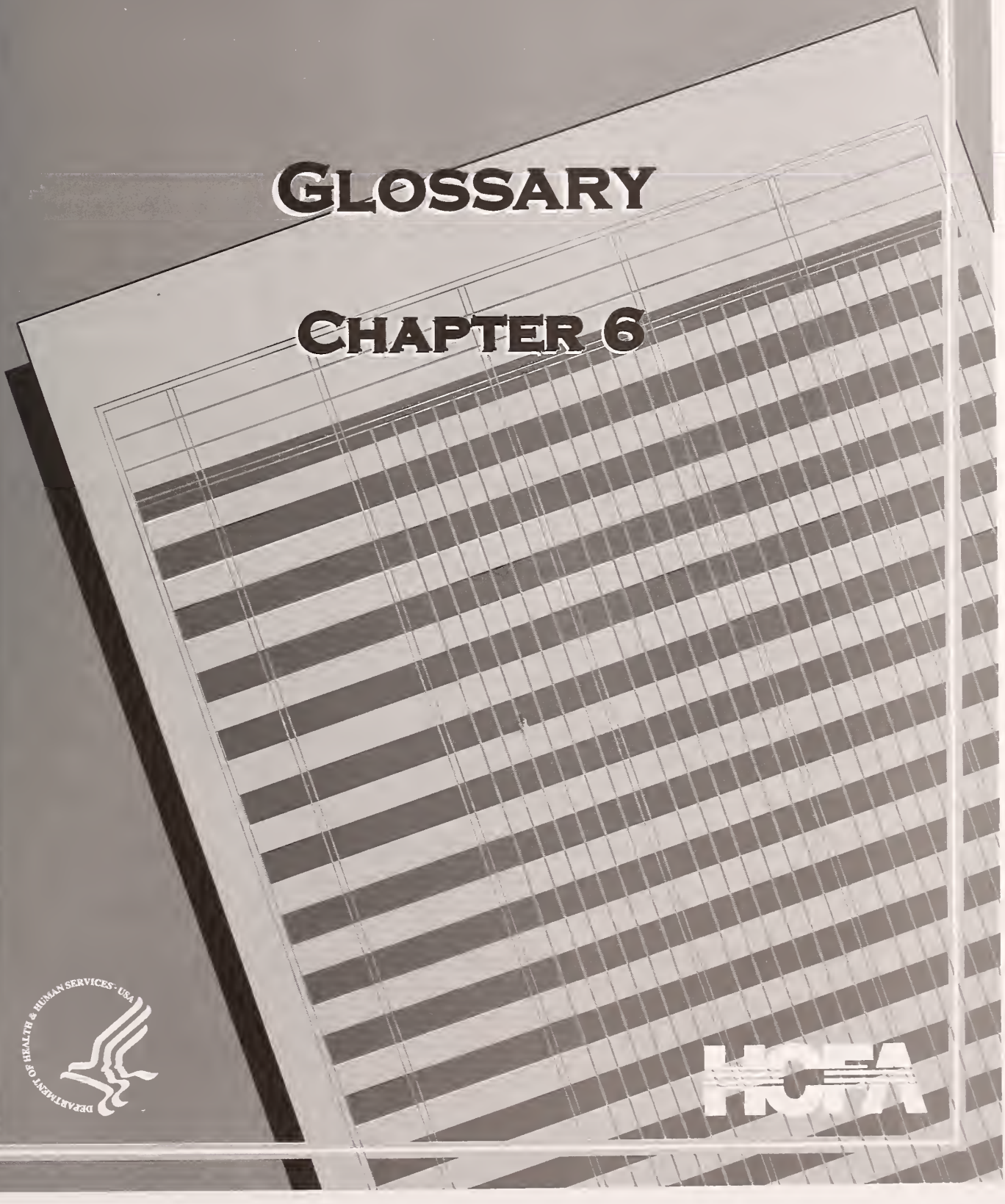
HCFA has performed this validation review in order to evaluate and report on the performance of the six approved laboratory accreditation organizations. In addition to the dialogue associated with the validation surveys, HCFA has been active in promoting opportunities for partnering with the accreditation organizations in furthering our mutual interest in improving clinical laboratory performance across the nation.

U.S. Department of Health and Human Services

Health Care Financing Administration

Glossary

Chapter 6



HCFA

GLOSSARY

Accrual Accounting : An accounting technique that recognizes costs when incurred and revenues when earned and includes the effect of accounts receivable and accounts payable when determining annual income.

Actuarial Soundness: A measure of the adequacy of Hospital Insurance and Supplementary Medical Insurance financing as determined by the difference between trust fund assets and liabilities for specified periods.

Administrative Costs: General term that refers to Medicare and Medicaid administrative costs, as well as HCFA administrative costs. Medicare administrative costs are comprised of the Medicare related outlays and non-HCFA administrative outlays. Medicaid administrative costs refer to the Federal share of the States' expenditures for administration of the Medicaid program. HCFA administrative costs are the costs of operating HCFA (e.g. salaries and expenses, facilities, equipment, rent and utilities, etc). These costs are reflected in the Program Management account.

Balanced Budget Act of 1997 (BBA): Major provisions include the Children's Health Insurance Program, Medicare+Choice, and expansion of preventive benefits.

Beneficiary: A person entitled under the law to receive Medicare or Medicaid benefits (also referred to as an "enrollee").

Benefit Payments: Funds outlayed or expenses accrued for services delivered to beneficiaries.

Carrier: A private business, typically an insurance company, which contracts with HCFA to receive, review, and pay physician and supplier claims.

Cash Accounting: An accounting technique that tracks outlays or expenditures during the current period regardless of the fiscal year the service was provided or the expenditure was incurred.

Children's Health Insurance Program (CHIP) (also known as Title XXI): This is a provision of the BBA that provides federal funding through HCFA to States so that they can expand child health assistance to uninsured, low-income children.

Cost-Based Health Maintenance Organization (HMO/Competitive Medical Plan, CMP): A type of managed care organization that will pay for all of the enrollees/members' medical care costs in return for a monthly premium, plus any applicable deductible or co-payment. The HMO will pay for all hospital costs (generally

referred to as Part A) and physician costs (generally referred to as Part B) that it has arranged for and ordered. Like a health care prepayment plan (HCPP), except for out-of-area emergency services, if a Medicare member/enrollee chooses to obtain services that have not been arranged for by the HMO, he/she is liable for any applicable deductible and co-insurance amounts, with the balance to be paid by the regional Medicare intermediary and/or carrier.

Durable Medical Equipment Regional Carrier (DMERC): A company that contracts to pay Medicare claims for purchased or rented items such as hospital beds, wheelchairs, or oxygen equipment used in a patient's home.

Demonstrations: Projects and contracts that HCFA has signed with various health care organizations. These contracts allow HCFA to test various or specific attributes such as payment methodologies, preventive care, social care, etc., and to determine if such projects/pilots should be continued or expanded to meet the health care needs of the Nation. Demonstrations are used to evaluate the effects and impact of various health care initiatives and the cost implications to the public.

Discretionary Spending: Outlays of funds subject to the Federal appropriations process.

Disproportionate Share Hospital (DSH): A hospital with a disproportionately large share of low-income patients. Under Medicaid, States augment payment to these hospitals. Medicare inpatient hospital payments are also adjusted for this added burden.

Durable Medical Equipment (DME): Purchased or rented items such as hospital beds, wheelchairs, or oxygen equipment used in a patient's home.

Expenditure: Expenditure refers to budgeted funds actually spent. When used in the discussion of the Medicaid program, expenditures refer to funds actually spent as reported by the States. This term is used interchangeably with Outlays.

Expense: An outlay or an accrued liability for services incurred in the current period. This term is used to show accrual accounting.

Federal General Revenues: Federal tax revenues (principally individual and business income taxes) not earmarked for a particular use.

Federal Insurance Contribution Act (FICA) Payroll Tax: Medicare's share of FICA is used to fund the HI Trust Fund. In FY 1995, employers and employees each contributed 1.45 percent of taxable wages, with no limitations, to the HI Trust Fund.

Federal Medical Assistance Percentage (FMAP): The portion of the Medicaid program which is paid by the Federal government.

Federal Managers' Financial Integrity Act FMFIA): A program to identify management inefficiencies and areas vulnerable to fraud and abuse and to correct such weaknesses with improved internal controls.

Health Care Prepayment Plan (HCPP): A type of managed care organization. In return for a monthly premium, plus any applicable deductible or co-payment, all or most of an individual's physician services will be provided by the HCPP. The HCPP will pay for all services it has arranged for (and any emergency services) whether provided by its own physicians or its contracted network of physicians. If a member enrolled in an HCPP chooses to receive services that have not been arranged for by the HCPP, he/she is liable for any applicable Medicare deductible and/or coinsurance amounts, and any balance would be paid by the regional Medicare carrier.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): Major provisions include portability provisions for group and individual health insurance, establishes the Medicare Integrity Program, and provides for standardization of health data and privacy of health records.

Hospital Insurance (HI): The part of Medicare that pays hospital and other institutional provider benefit claims. See "Part A."

Information Technology (IT): The term commonly applied to maintenance of data through computer systems.

Intermediary: A private business, typically an insurance company, which contracts with HCFA to receive, review, and pay hospital and other institutional provider benefit claims.

Internal Controls: Management systems and policies for reasonably documenting, monitoring, and correcting operational processes to prevent and detect waste and to ensure proper payment. Also known as Management controls.

Mandatory Spending: Outlays for entitlement programs (Medicare and Medicaid) that are not subject to the Federal appropriations process.

Material Weakness: A serious flaw in management or internal controls requiring high-priority corrective action.

Medicare Current Beneficiary Survey (MCBS) : A comprehensive source of information on the health, health care, and socioeconomic and demographic characteristics of aged, disabled, and institutional Medicare beneficiaries.

Medicare Contractor: A collective term for carriers and intermediaries.

Medicare+Choice: A provision in the BBA that restructures HCFA's authority to contract with a variety of managed care entities, including health maintenance organizations (HMO) and Competitive Medical Plans (CMP), both of which were previously allowed to participate in Medicare, as well as preferred provider organizations (PPO) and preferred supplier organizations (PSO), religious fraternal benefit society plans, private fee-for-service-plans, and medical saving accounts (MSAs), for which the BBA authorizes a special demonstration for up to 390,000 beneficiaries.

Medicare Integrity Program (MIP): A provision in HIPAA that sets up a revolving fund to support HCFA's program integrity program.

Medicare Trust Funds: Treasury accounts established by the Social Security Act for the receipt of revenues, maintenance of reserves, and disbursement of payments for the HI and SMI programs.

Medical Review/Utilization Review (MR/UR): Contractor reviews of Medicare claims to ensure that the service was necessary and appropriate.

Medicare Secondary Payer (MSP): A statutory requirement that private insurers providing general health insurance coverage to Medicare beneficiaries pay beneficiary claims as primary payers.

Obligation: Budgeted funds committed to be spent.

Outlay: Budgeted funds actually spent. When used in the discussion of the Medicaid program, outlays refer to amounts advanced to the States for Medicaid benefits. Used for cash accounting.

Part A: The part of Medicare that pays hospital and other institutional provider benefit claims, also referred to as Medicare Hospital Insurance or "HI."

Part B: The part of Medicare that pays physician and supplier claims, also referred to as Medicare Supplementary Medical Insurance or "SMI."

Payment Safeguards: Activities to prevent and recover inappropriate Medicare benefit payments, including MSP, MR/UR, provider audits, and fraud and abuse detection.

Peer Review Organization (PRO): PROs monitor the quality of care provided to Medicare beneficiaries to ensure that health care services are medically necessary, appropriate, provided in a proper setting, and are of acceptable quality.

Program Management: HCFA's operational account. Program Management supplies the agency with the resources to administer Medicare, the Federal portion of Medicaid, and other Agency responsibilities. The components of Program Management are: Medicare contractors, survey and certification, research, and administrative costs.

Provider: A health care professional or organization providing medical services.

Recipient: An individual covered by the Medicaid program, however, now referred to as a beneficiary.

Risk-Based Health Maintenance Organization (HMO)/ Competitive Medical Plan (CMP): A type of managed care organization. After any applicable deductible or co-payment, all of an enrollee/member's medical care costs are paid for in return for a monthly premium. However, due to the "lock-in" provision, all of the enrollee/member's services (except for out-of-area emergency services) must be arranged for by the risk-HMO. Should the Medicare enrollee/ member choose to obtain service not arranged for by the plan, he/she will be liable for the costs. Neither the HMO nor the Medicare program will pay for services from providers that are not part of the HMO's health care system/network.

Revenue: The recognition of income earned and the use of appropriated capital from the rendering of services in the current period.

Self Employment Contribution Act (SECA) Payroll Tax: Medicare's share of SECA is used to fund the HI Trust Fund. In Fiscal Year 1995, self-employed individuals contributed 2.9 percent of taxable annual income, with no limitation.

State Certification: Inspections of Medicare provider facilities to ensure compliance with Federal health, safety, and program standards.

Supplementary Medical Insurance (SMI): The part of Medicare that pays physician and supplier claims. See "Part B."

Tax and Donations: State programs under which funds collected by the State through certain health care related taxes and provider-related donations were used to effectively increase the amount of Federal Medicaid reimbursement without a comparable increase in State Medicaid funding or provider reimbursement levels.

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